THE IMPACT OF THE HEALTH CARE LAW ON THE ECONOMY, EMPLOYERS, AND THE WORKFORCE

HEARING

BEFORE THE

COMMITTEE ON EDUCATION AND THE WORKFORCE U.S. HOUSE OF REPRESENTATIVES

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C O N T E N T S

THE IMPACT OF THE HEALTH CARE LAW ON THE ECONOMY, EMPLOYERS, AND THE WORKFORCE

Wednesday, February 9, 2011
U.S. House of Representatives
Committee on Education and the Workforce
Washington, DC

The committee met, pursuant to call, at 10:01 a.m., in room 2175, Rayburn House Office Building, Hon. John Kline [chairman of the committee] presiding.

Present: Representatives Kline, Biggert, Platts, Foxx, Roe, Thompson, Walberg, DesJarlais, Hanna, Rokita, Bucshon, Barletta, Noem, Roby, Heck, Ross, Kelly, Miller, Kildee, Payne, Andrews, Woolsey, Hinojosa, McCarthy, Tierney, Kucinich, Wu, Holt, Davis, Grijalva, Bishop, Loebsack, and Hirono.

Staff present: Kirk Boyle, General Counsel; Casey Buboltz, Coalitions and Member Services Coordinator; Ed Gilroy, Director of Workforce Policy; Jimmy Hopper, Legislative Assistant; Marvin Kaplan, Professional Staff Member; Barrett Karr, Staff Director; Ryan Kearney, Legislative Assistant; Brian Newell, Press Secretary; Molly McLaughlin Salmi, Deputy Director of Workforce Policy; Ken Serafin, Workforce Policy Counsel; Linda Stevens, Chief Clerk/Assistant to the General Counsel; Loren Sweatt, Professional Staff Member; Joseph Wheeler, Professional Staff Member; Aaron Albright, Minority Press Secretary; Tylease Alli, Minority Hearing Clerk; Jody Calemine, Minority General Counsel; Brian Levin, Minority New Media Press Assistant; Jerrica Mathis, Minority Legislative Fellow; Megan O'Reilly, Minority Labor Counsel; Julie Peller, Minority Deputy Director of Policy and Planning; Meredith Regine, Minority Policy Associate, Labor; Melissa Salmanowitz, Minority Press Secretary; Michele Varnhagen, Minority Labor Policy Director; Daniel Weiss, Minority Special Assistant to the Chairman; and Mark Zuckerman, Minority Staff Director.

Chairman KLINE [presiding]. A quorum being present, the committee will come to order. Well, good morning, everyone, and welcome. Today's hearing is the first opportunity for this committee to take a close look at the consequences of the health care reform bill that was signed into law last year. It has been less than a year, and already this 2,700-page law has led to more than 4,000 pages in new government regulations.

A proposal designed to reduce health care costs will instead increase national health care spending by $311 billion. And during

a time of stubbornly high unemployment, job creators are forced to wrestle with the uncertainty of what the law and its new regulations mean and how that all fits into their plans for the future.

Employers already struggling to keep their doors open now must choose between higher health care costs or costly penalties. To suggest this doesn't undermine job creation is, I believe, to deny reality.

Recently, a number of small-business owners were asked how they are adjusting to the new health care law. Their answers help provide a snapshot of what our economy is facing and will continue to face if the law isn't replaced.

Blake Haynie, resident of Georgia and owner of Action Signs, Incorporated, said, "I will lay off the necessary number of employees to cover the extra costs." Gary Crosby, who owns Gary Crosby Construction in my home state of Minnesota, said he will "have fewer employees." Catherine Marsh of Botkins, Ohio replied, "reducing staff, cutting benefits."

And Darcy Gunn of Loveland, Colorado declared, "I have never laid off any employees. The last thing I need is more expenses. This is the wrong time to hurt small-business owners. I will have to pull the plug."

These are honest responses to a government takeover of one-sixth of the economy. Behind every story of a small-business owner struggling to meet the demands of the law's mandates and penalties is the reality of a workforce with fewer jobs and opportunities for workers and families.

I anticipate supporters of the law with have their own stories to share as they seek to convince the American people that meaningful health care reforms are only possible as part of this costly government takeover. The American people reject this false choice, and we are here today to begin fulfilling our promise to find a better way.

Today we will also examine what changes the law is imposing on employer-sponsored health care plans. This committee has broad jurisdiction over health insurance provided through the workplace, coverage that affects roughly 170 million Americans. By the administration's own estimates, up to 69 percent of all business health plans and 80 percent, 80 percent of small business health plans will soon see significant changes to the benefits they provide. This has a potential to undermine the health care coverage of tens of millions of Americans.

We need to understand what those changes are and how insurers, employers and individuals are responding.

If there is one business that has benefited from the new law, it is the blooming waiver business, operated at the Department of Health and Human Services. HHS has issued 733 waivers that exempt the health care plans of various businesses, organizations and unions from the law's requirements.

No one can be faulted for seeking an exemption. It is, however, interesting to see so many who extolled the virtues of this health care law now seeking relief from it. This is one of the many areas of this vast law that calls for further exploration.

I want to thank our witnesses for being here today. We look forward to your testimony.

[The statement of Chairman Kline follows:]

Prepared Statement of Hon. John Kline, Chairman, Committee on Education and the Workforce

A quorum being present, the Committee will come to order.

Good morning everyone and welcome. Today's hearing is the first opportunity for this Committee to take a close look at the consequences of the health care reform bill that was signed into law last year.

It has been less than a year and already this 2,700 page law has led to more than 4,000 pages in new government regulations. A proposal designed to reduce health care costs will instead increase national health care spending by $311 billion. And during a time of stubbornly high unemployment, job creators are forced to wrestle with the uncertainty of what the law and its new regulations mean and how that all fits into their plans for the future.

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This is one of the many areas of this vast law that calls for further exploration. I want to thank our witnesses for being here today; we look forward to your testimony. I will now recognize my distinguished colleague George Miller, the senior Democratic member of the committee, for his opening remarks.

Chairman KLINE. I will now recognize my distinguished colleague, George Miller, the senior Democratic member of the committee, for his opening remarks.

Mr. MILLER. Thank you very much, Chairman Kline, for calling this hearing.

And I want to welcome our witnesses to this hearing and look forward to their testimony. There have been many predictions about the new health care law, how the new health care law would

affect our nation's economy. The debate has been heated. Misinformation about the law has bred fear and division among the public.

I hope that we can put rhetoric and misinformation aside, that we will openly and honestly examine the law that is now in effect but still has several years to go before it is fully implemented. The Affordable Care Act is not perfect. It does not contain everything that I wanted. And it includes many things that some of my colleagues oppose. That is the nature of lawmaking.

But the new law has unquestionably begun to deliver positive results for small businesses, for large employers, for individuals, children, their families and the elderly. It has begun to work for small businesses.

Dr. Odette Cohen, who runs a small pediatrics practice in Willingboro, New Jersey has testified in recent hearings that the small-business tax credit is keeping her employees covered. Thanks to the lower health care costs, Dr. Cohen is hiring another nurse practitioner and upgrading her business with electronic record-keeping system.

And she said that she was eagerly awaiting the creation of the state-based health insurance exchanges in 2014, which will allow her to pool together with other small businesses to improve choices and drive down the costs, just the way large companies do. And hopefully, she will get rid of that 18 percent more she is paying for the same plans as large businesses offer.

Dr. Cohen is not alone in benefiting from the new law. The recent Kaiser Family Foundation survey found that the number of small businesses offering insurance has increased by 30 percent this last year.

The new law works for large employers, too. Helen Darling, the president of the National Business Group on Health, that represents more than 300 large employers, including 65 of the Fortune 100, has said that our nation's businesses would be worse off if the law was repealed. The new law benefits working people. Workers are already enjoying new rights and protections that put them in charge of their health care.

Never again will they have to worry about losing their health insurance if they lose or change their job or decide to start their own business. The new law is literally keeping people alive.

More than a million young adults have been able to join their parents' health plans. Nearly 16 million Americans are no longer vulnerable to the insurance companies dropping them from coverage when they need it the most. That is when they are sick.

And 165 million people no longer are subject to the annual and lifetime benefit caps that rob them of coverage at the exact time that they need it. Children with preexisting conditions are no longer denied coverage. And in 2014, the same will be true for adults.

And the new law also works for the overall economy. Since President Obama signed the Affordable Care Act, 1.1 million private sector jobs have been created, more jobs than in the entire 8 years of the Bush administration.

The Wall Street Journal recently reported that the IPO market is gaining momentum. Seven of the 11 companies going public last

week were in the health care-related industries, taking advantage of the new opportunities to make health care more efficient with new technologies and new systems guidance.

The Health Care Act is now the law of the land. And it is working. It reigns in the power of the insurance companies that have unfairly wielded over ordinary Americans' lives. If Congress were to repeal this law, small businesses, families with children, workers and elderly would be harmed immediately. Their taxes would go up, the rights and benefits overturned, and their access to quality, affordable care taken away.

I look forward to today's hearing. And I yield back the balance of my time.

Mr. Chairman, I would like to just take a moment before we get into the hearing. Today's hearing will be the last hearing for the committee's Democratic staff director, Mark Zuckerman. Where is Mark? Right here, right behind us.

Mark will be joining the White House staff as the new deputy to Melody Barnes in the domestic policy council. Mark has been a trusted adviser and a friend. Since 1996, Mark has been through every labor and education battle with me, helping to keep our promise to America's working families.

Student loan programs are more reliable. Workers are afforded more rights. Patients are protected because of the work that Mark has done. I know his wife, Paula, and his children, Naomi and Noah, are as proud of him as I am and that he is taking this next step on his journey.

Thank you, Mark, for all of your dedicated service to the committee on both sides of the aisle and for the committee's work on behalf of families. [Applause.]

Mr. MILLER. Stand up for a minute. Just stand up. [Applause.]

Thank you. Thank you, Mr. Chairman.

[The statement of Mr. Miller follows:]

Prepared Statement of Hon. George Miller, Senior Democratic Member, Committee on Education and the Workforce

Thank you Chairman Kline for calling this hearing.

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Helen Darling, president of the National Business Group on Health that represents more than 300 large employers including 65 of the Fortune 100, said that our nation's businesses would be worse off if the law is repealed.

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Workers are already enjoying new rights and protections that put them in charge of their own health care. Never again will they have to worry about losing health insurance if they lose or change their job or decide to start their own business.

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If Congress were to repeal this law, small businesses, families with children, workers, and the elderly would be harmed immediately. Their taxes would go up, new rights and benefits overturned, and their access to quality, affordable health care taken away.

Mr. Chairman, I look forward to today's hearing and I yield back my time.

Chairman KLINE. Mark, thank you for your service, your years of service to the committee. And congratulations on your new assignment. I am sure that will be a great adventure. Well, I hope it will be a great adventure for you. And anyway, congratulations.

Pursuant to committee rule 7-C, all members will be permitted to submit written statements to be included in the permanent hearing record. Without objection, the hearing record will remain open for 14 days to allow statements and other extraneous material referenced during the hearing to be submitted for the official hearing record.

It is now my pleasure to introduce our distinguished panel of witnesses. And I will go through and sort of introduce each of you, a little bit of bio before we get into the testimony.

Dr. Paul Howard is a senior fellow at the Manhattan Institute and serves as director of the institute's Center for Medical Progress. He has written on a wide variety of medical policy issues, including health care reform, medical malpractice and Medicare policy initiatives. He received his Ph.D. in political science from Fordham University, is a graduate of the College of the Holy Cross in Worcester, Massachusetts.

Ms. Gail Johnson is the president and CEO of Rainbow Station, Incorporated, a nationally accredited preschool and school-age recreation franchise based in Richmond, Virginia that offers backup daycare for mildly ill children on-site. Before starting her own business, Ms. Johnson worked as a pediatric nurse for almost 25 years and served as a faculty member of the Maternal Child Nursing Departments at the Medical College of Virginia, Virginia Commonwealth University. She continues to serve as the vice president of the Medical College of Virginia Foundation Board of Trustees.

Dr. Paul Van de Water is a senior fellow at the Center on Budget and Policy Priorities, where he specializes in Medicare, Social Security and health coverage issues. He formerly served as assistant deputy commissioner for policy at the Social Security Administration and worked for over 18 years at the Congressional Budget Office. Dr. Van de Water holds an A.B. in economics from Princeton University and a Ph.D. in economics from Massachusetts Institute of Technology.

Mr. Neil Trautwein is the vice president and employee benefits policy council at the National Retail Federation. As such, he leads National Retail Federation's work on health care reform and other benefits-related legislation and regulatory issues. He holds a bachelor's degree in political science from the University of Louisville and a law degree from George Washington University.

Okay. You have in front of you—I think some of you have been here before and certainly seen this. You have the little box there. And it has a light system. When you start your testimony, the little green light will come on. And 4 minutes into your testimony, assuming that Ken's finger and timing is exactly correct, it will turn yellow. And that gives you about a 1-minute heads up that your 5 minutes is coming to a close.

And when your 5 minutes is up, a red light will come on. I have no intention of dropping the gavel in the middle of any sentence, but please, try to wrap up your testimony. And be aware that your entire testimony will be included in the record.

And while I am on it, when we get to questions, I want to remind my colleagues that we will be under the 5-minute rule. And out of fairness to our colleagues, I will be a little bit more prompt in dropping the gavel. Let us try to keep our questions and answers to 5 minutes.

Okay. I think we are ready to go. We will start with Dr. Howard.

Sir, you are recognized.

STATEMENT OF PAUL HOWARD, SENIOR FELLOW, MANHATTAN INSTITUTE

Mr. HOWARD. I would like to thank Chairman Kline, Ranking Member Miller and the other honored members of the committee for the opportunity to speak this morning on the economic and employment effects of the Patient Protection and Affordable Care Act. I am speaking today from my experience studying health care policy, speaking with providers, patients and employers from across the country and from my own research on health care as director and senior fellow at the Manhattan Institute's Center for Medical Progress.

First of all, I would like to state that real health care reform that lowers costs and improves access to affordable coverage is a critical national priority for employers, for the uninsured and for taxpayers. Unfortunately, the Patient Protection and Affordable Care Act doubles down on many of the worst aspects of our current system while adding new cost pressures that will serve as a drag on economic growth and job growth for years to come.

In turn, I will discuss why the Affordable Care Act is much more likely to increase the deficit than to lower it, explain how the mandates and penalties that it imposes on insurers and employers will

increase health care costs and decrease employment and conclude by explaining the negative effects of regulatory uncertainty at a time when companies are sitting on trillions of dollars in cash that could be used for job creation.

Even if we take the Affordable Care Act at face value, many experts believe that it has not done nearly enough to address current and project entitlement spending. The CBO does score the Affordable Care Act as reducing the deficit by $143 billion in its first decade. However, current savings estimates double-count $52 billion in Social Security payments and $70 billion in premium payments for a new long-term care program as revenues. It also gears up to $115 billion in discretionary costs, including $10 to $20 billion in direct implementation costs.

Defenders of the act like to point to the increased savings in the second decade of the legislation. The problem with this defense is that the Office of the Medicare Actuary has noted that most of these cuts will be unsustainable. We should also note that states will face $21 billion in new Medicaid costs from 2014 to 2019, not including up to $12 billion in new administrative outlays. Many state budgets face significant budget deficits today and cannot afford any new spending.

The Affordable Care Act also imposes a number of new minimum benefit requirements on insurers. These provisions may result in what is perceived to be a richer benefit package, but at the cost of higher insurance premiums that employers will have to offset to reduce employee wages and fewer jobs.

New taxes on drug companies, insurance companies and medical device companies are all likely to be passed——

Chairman KLINE. Dr. Howard, let me—I am sorry to interrupt. But we are having microphone difficulties. And it has been suggested that maybe you move the microphone away from you just a little bit. And we can hear what you are saying, but it is a mechanical problem. So I didn't mean to interrupt. We will try again. And then we will just power through.

Mr. HOWARD. Would you like me to start again? Or——

Chairman KLINE. No.

Mr. HOWARD. Okay. The Affordable Care Act also imposes a number of new minimum benefit requirements on insurers. These provisions may result in what is perceived to be a richer benefit package, but at the costs of higher insurance premiums that employers will have to offset through reduced employee wages or fewer jobs. New taxes on insurers, drug companies and medical device companies are all likely to be passed through directly onto employers.

The administration has repeatedly promised that if you like the coverage you have today, you will be able to keep it. But current estimates are that 69 percent of all employers and up to 80 percent of small employers will lose their grandfathered plans over the next several years.

The mandate is apt to have a variety of negative effects on coverage and employment decisions. For employers with 50 or fewer employees who do not offer coverage, it will be a disincentive to grow beyond the cap and incur the penalty. Other mid-sized firms will likely hire fewer lower wage workers, more part-time workers

or become more automated in order to reduce their exposure to the penalty.

Of course, many companies may rationally decide that the price of dropping coverage is more than offset by the savings recouped from ending employer-based coverage. The decision to end coverage will also be encouraged by the fact that the Affordable Care Act offers significantly larger subsidies through the state exchanges than many employees will receive through employer-based coverage.

Employers will face tremendous uncertainty over the next several years as they try to understand their exposures to the costs associated with the federal and state insurance requirements, creating a substantial drag on job creation. Employers are already struggling with the unintended consequences of the legislation.

To date, the Department of Health and Human Services had to issue over 700 waivers from minimum benefit requirements under the Affordable Care Act. Over 200 economists have also sent a letter to the House leadership on January 18th discussing the enormous costs of the legislation and its negative effect on employment. A different, better approach for the U.S. is to rely on incremental reforms to expand coverage to those with greatest need, implement tax reforms to equalize the tax treatment of insurance purchased on the individual market or through employers and institute health care and insurance reforms that utilize competition and consumer choice to drive health care costs down.

Members of the committee, I thank you for the opportunity to be here today. And I look forward to answering your questions.

[The statement of Mr. Howard follows:]

Prepared Statement of Paul Howard, Ph.D., Senior Fellow and Director, Center for Medical Progress, Manhattan Institute for Policy Research

I'd like to thank Chairman Kline, Ranking Member Miller and members of the Committee for the opportunity to speak this morning on the effects of the Patient Protection and Affordable Care Act on the economy, employers and the workforce.

I'm speaking today from my experience studying health care policy; speaking with providers, patients, and employers from across the country; and from my own research on health care as director and senior fellow at the Manhattan Institute's Center for Medical Progress.

First of all, I'd like to state that there is a critical need for real health care reforms that improve access to affordable health insurance; protect individuals and families from the risk of catastrophic health care expenses; lower the unsustainable rate of health care cost growth for private and public payers; and create better incentives for health care providers to offer more cost effective care.

Creating truly portable individual health insurance would reduce the incidence of job-lock, encouraging entrepreneurship and allowing employees to changes jobs without fear of losing valuable health insurance. Slowing the rate of insurance premium growth for employer-based coverage would allow employers to shift scarce capital to other critical business operations (including job creation) and/or increase employee compensation in the form of higher take home pay.

Without significant health care reforms, rising employer health insurance premiums will continue to sap business capital and erode employee take home pay. More businesses (especially small employers) will drop coverage as insurance becomes unaffordable, leading to an ever growing number of uninsured. Entitlement spending for Medicare and Medicaid will swamp state and federal budgets, threatening economically crippling tax increases or devastating spending cuts.

Unfortunately, the Patient Protection and Affordable Care Act is not the solution to our health care woes. If anything, the Affordable Care Act "doubles down" on many of the worst aspects of our current system, while adding new cost pressures and problems that will serve as a drag on economic growth and job creation for years to come.

I believe that the negative economic impacts of the Affordable Care Act can be separated into three broad categories:

- PPACA will Increase the Deficit, Not Reduce It
- PPACA will Increase Insurance Costs and Reduce Employment
- Regulatory Uncertainty under PPACA will Hinder Job Creation

In turn, I will discuss why the Affordable Care Act is much more likely to increase the deficit than reduce it; explain how the mandates, taxes, and penalties that it imposes on insurers and employers will increase health care costs and decrease employment; and conclude by exploring the negative effects of regulatory uncertainty at a time when companies are "sitting" on trillions of dollars in cash that could be used for job creation.

PPACA will Increase the Deficit, Not Reduce It

From an economic perspective, reducing the federal deficit to sustainable levels would be an enormous boon for U.S. economic competitiveness and job creation. If we continue spending at current projected levels, the U.S. economy will be exposed to the risk of a sovereign debt crisis that would force economically crippling tax increases or sudden and severe cuts in government spending that would have long lasting negative consequences for U.S. economic growth and employment.

Slowing the rate of excess health care cost growth for government health care entitlement programs like Medicare and Medicaid would be a significant step towards addressing the U.S.'s long term structural deficit. However, the Affordable Care Act creates a new middle class entitlement for the purchase of heavily subsidized private health insurance, and approximately doubles the size of the Medicaid program. This is hardly the best way to "bend the curve" of health care spending, since it creates large new constituencies for increased health care spending and increased demand is likely to put significant upward pressure on the cost of health care goods and services.

The Affordable Care Act does contain what MIT economist Jonathan Gruber calls (approvingly) a "spaghetti approach to cost control".[i] This includes a grab-bag of Medicare pilot projects and payment reforms including Accountable Care Organizations, bundled payment systems, and pay-for-performance initiatives. The strategy, insofar as it can be called a strategy, is to throw "a bunch of stuff at against the wall [to] see what sticks."

Unfortunately, these programs are underpowered, and are likely to be cut short whenever they work too effectively, and threaten the interests of one or another powerful health care interest group.

The Affordable Care Act's focus on top-down planning also ignores the myriad unintended consequences that follow when bureaucracies with limited information attempt to control the behavior of hundreds of thousands of physicians, and thousands of hospitals, who have powerful financial incentives to find ways to maximize revenue from administratively favored activities and procedures and avoid painful cuts to disfavored ones.

Even if we take the Affordable Care Act at face value, it has not done nearly enough to address current and projected entitlement spending. Just two months after the Affordable Care Act passed, the director of the Congressional Budget Office (CBO) noted that:

Rising health care costs will put tremendous pressure on the federal budget during the next few decades and beyond. In CBO's judgment, the health legislation enacted earlier this year does not substantially diminish that pressure.[ii]

Nonetheless, it has been endlessly repeated that the Affordable Care Act will actually reduce the deficit by a small amount in its first ten years and by trillions of dollars thereafter. How is this circle squared? The federal government is clearly committed to spending hundreds of billions more on Medicaid, the State Children's Health Insurance Plan (or SCHIP), and new subsidies for middle- and upper income-uninsured to buy health insurance on newly created state health insurance exchanges beginning in 2014.

Still, the CBO does score the Affordable Care Act as reducing the deficit by about $143 billion in its first decade (including $19 billion from its education related provisions). However, the CBO also notes that the federal government will spend about $401 billion more on health care programs in the Affordable Care Act's first decade, while increasing federal revenues, through taxes and fees, by an even greater amount, $525 billion.[iii]

Consequently, half-a-trillion dollars will be shifted out of the private economy and directed largely towards new health care spending. Not only will this reduce funds available for private sector job growth and innovation, but the funds are also lost for any future deficit reduction efforts. Estimates that the Affordable Care Act reduces the deficit by $143 billion seem reassuring, but only if we ignore the fact that

we are shifting substantial new revenues from non-health care sources to meet new health care obligations—hardly "bending the curve" by any plausible definition.

The passage of the Affordable Care Act also set a new low in Washington's perennial fiscal shell games. First of all, the legislation double-counts $53 billion in Social Security payments and $70 billion in premium payments for a new long term care insurance program (CLASS) as revenues. It also ignores up to $115 billion in discretionary costs associated with the Affordable Care Act, including $10-20 billion in direct implementation costs,[iv] including:

• $5-10 billion for the IRS associated with "the eligibility determination, documentation, and verification processes for premium and cost-sharing credits"

• $5-10 billion in costs for a variety of federal agencies including CMS, the Office of Personnel Management, Medicaid and CHIP

Many more costs loom just over the horizon. The infamous "doc fix" for the sustainable growth rate (SGR) formula under Medicare threatens large cuts to physicians fees every year. Congress passed the latest SGR patch in December and deferred cuts for 2011, without offering any permanent resolution. Ultimately the SGR has to be addressed, but the fiscal cost is staggering: estimated at $276 billion over 10 years. The CBO also estimates that costs for the new insurance subsidies and Medicaid expansion under the Affordable Care Act will grow by approximately 8% annually beginning in 2019.

Defenders of the Affordable Care Act may concede that the near term prospects for the bill to control costs are poor. Instead, they point to the increased savings in the second decade of the legislation, and to the 2010 Medicare Trustees report, which estimates that the Affordable Care Act will extend Medicare's hospital insurance trust fund an additional 12 years (from 2017 to 2029), and cut trillions from Medicare's long-term expenditures.

The problem is that these figures assume that Congress will tolerate large cuts to payments for Medicare providers or that such cuts will have no effect on services for Medicare beneficiaries. The office of the Medicare Actuary has published what amounts to a dissent from the 2010 Trustees report, noting that:

[T]he financial projections shown in this report for Medicare do not represent a reasonable expectation for actual program operations * * * the statutory reductions in price updates for most categories of Medicare provider services will not be viable.[v]

Medicare actuaries estimate that by 2019, Medicare payment rates would be lower than those currently paid for Medicaid (which already pays providers much less than private insurance). In the long run, Medicare payments would dip to "one-third of the relative current private health insurance prices and half of those for Medicaid," according to the actuaries' memorandum. Under these projections, a full 15% of Medicare providers would be unprofitable by 2019, 25% by 2030, and 40% by 2050.[vi] Needless to say, it is unlikely that Congress would actually allow these cuts to go into effect, since they would have dire consequences for Medicare beneficiaries.

Other analysts, after discounting the double-counting of revenues and cuts that are likely to be unsustainable, put the true deficit costs of the Affordable Care Act during its first 10 years at over $562 billion and second decade at over $1.5 trillion.[vii] Meeting these obligations will require significant new tax increases or spending cuts, draining funds from the private sector or reducing investment for other critical priorities like public education and infrastructure.

We should also not ignore the serious impact that the Affordable Care Act will have on already strained state budgets. The new law would bring 16 million Americans—one-half of the estimated 32 million who will receive new insurance coverage—into Medicaid, covering Americans making up to 133 percent of the federal poverty level.

Medicaid spending currently consumes about 20 percent of state budgets, crowding out spending on everything from education to infrastructure. The federal government will pick up 100 percent of new Medicaid costs for the first several years after 2014, when the law goes into effect, paring back to 90 percent in 2020. Still, states will face $21 billion in new Medicaid costs from 2014-2019,[viii] not including up to $12 billion in new administrative costs.[ix] While this pales besides the $443 billion in new Medicaid costs for the federal government, many state budgets are in such poor condition that they can't afford any new outlays; they need, in fact, to cut spending.

States will also be responsible for the approximately 11 million uninsured Americans who are currently eligible for Medicaid but have never bothered to enroll. In 2014, once the Affordable Care Act takes effect, many of these eligible but not enrolled people will presumably sign up for Medicaid coverage. Unfortunately for the states, these enrollees would be covered not under the higher federal matching rate that the Affordable Care Act establishes but under the pre-PPACA rate, which var-

ies by state but is much more onerous. These trends will only increase Medicaid pressures on state budgets, leading to more economically damaging tax increases, budget cuts, or state employee layoffs.

PPACA will Increase Insurance Costs and Reduce Employment

While the full deficit effects of the Affordable Care Act are not likely to be felt for several years after full implementation begins in 2014, the Act also contains a number of other provisions including new insurance mandates, taxes, and employer penalties that will have a direct and more immediate effect on the cost of health insurance coverage and employer decisions to hire (or not hire) additional employees.

The Affordable Care Act imposes a number of new requirements on insurers, including extending dependent coverage for adult children until they are 26; eliminating the lifetime cap on health insurance coverage and gradually increasing and then eliminating annual coverage limits; forbidding companies from excluding children with pre-existing conditions from child-only coverage policies; and eliminating cost-sharing for preventive services in Medicare and private plans. These provisions may result in what is perceived to be a "richer" benefit package, but at the cost of higher insurance premiums that employers will have to offset through reduced employee wages or job creation.

New taxes on insurance companies, pharmaceutical companies, and medical device companies are all likely to be passed through directly onto employers and employees in the form of higher insurance premiums. (Some of these new costs can, of course, also be passed along to consumers in the form of higher prices for goods and services.)

The administration has also repeatedly promised that "if you like your plan, you can keep it, and thus that "grandfathered" plans would not be subject to new insurance regulations, and new costs. However, the government has since revealed that up to 69 percent all employers (and up to 80 percent of small employers) will lose their grandfathered status over the next several years and be subject to new regulatory requirements and costs.[x]

Massachusetts' experience with health insurance reform, the template for the Affordable Care Act, suggests that health insurance costs will rise for employers and for small firms in particular. A July 2010 study by health economists John Cogan, Glenn Hubbard, and Daniel Kessler found that premium trends for employer-provided health insurance rose faster in the Bay State after reforms were implemented, particularly for individual coverage and for small businesses.

The authors found that "health reform in Massachusetts increased single coverage employer-sponsored insurance premiums by about 6 percent in aggregate and by about 7 percent for firms with fewer than 50 employees. * * * For small employers, the differential Massachusetts/US growth in small group [family] premiums from 2006-2008, over and above the growth from 2004-2006, was 14.4 percent."[xi]

The Affordable Care Act also contains a play or pay mandate that penalizes companies with more than 50 employees who do not offer coverage, or offers "unaffordable" coverage if one or more employees at the firm purchases subsidized coverage on a state health insurance exchange beginning in 2014.

The consulting firm Mercer predicts that "more than a third of the nation's employers—38%—have at least some employees for whom coverage would be considered 'unaffordable' under [PPACA]." The penalty is equal to $3,000 per full-time employee receiving subsidized coverage, or $2,000 per FTE excluding the first 30, whichever is less. (Although Mercer found that more small companies would be affected by the penalty, 31% of employers with 500 or more employees would be at risk, along with 20% of employers with 20,000 or more employees.)

The "play or pay" mandate is apt to have a variety of effects on coverage and employment decisions. For employers with 50 or fewer employees who do not offer coverage, it will be a disincentive to grow beyond the "cap" and incur the penalty—reducing employment. One labor economist notes that the $2,000 penalty will amount to 15% of average wages in the restaurant industry and nearly 10% of wages in the retail sector—providing an incentive for firms to hire fewer lower-wage workers or become more automated. (In general, firms will also prefer to hire full-time workers as the cost of benefits per-hour of labor is lower.)[xii]

For employers who do not offer "affordable" coverage, they can avoid the penalty by increasing spending on health care benefits to reduce the employees' share of health insurance costs below the 9.5% threshold of household income. However, these expenditures would compete with total employee compensation or other employment decisions. (How, exactly, firms will go about learning their employees' household income for purposes of determining if their coverage is "affordable"—

household income may fluctuate throughout the year—is another question entirely, with potentially troubling privacy implications.)

Of course, many companies may rationally decide that the "price" of dropping coverage (along with any increase in an employees' salary or other compensation) is more than offset by the savings recouped from ending an employee insurance policy that costs $11,000 or more annually.[xiii]

The decision to end employer-based coverage will also be encouraged by the fact that the Affordable Care Act effectively creates a "most favored subsidy" group, insofar as individuals and families in the exact same income bracket may qualify for very different tax subsidies based on whether or not they are offered employer-based insurance coverage.

The subsidies and cost sharing support available on the state health insurance exchanges are significantly more generous than the current insurance tax exemption for employer provided health insurance—at least for households earning less than 200-250 percent of the federal poverty level—providing an additional incentive for low-wage employees to migrate into the exchange. (Higher-wage employees who do not qualify for subsidies on the exchanges, or who would still face substantial out of pocket costs, will want to "stay put" in employer-based coverage.)

The Affordable Care Act does contain a tax credit to offset the costs of insurance coverage for small firms. The credit, however, phases out for firms with between 10-25 employees and as average wages approach $50,000. Proprietors and their family members are also excluded from claiming the credit, even though many small firms are family-run. Given these limitations, the National Federation of Independent Businesses estimates that only 35 percent of firms with fewer than 25 employees will be able to qualify for the credit. In any case, the premium is only available for a total of six years (2010-13, plus a two year credit beginning in 2014).

Although it is difficult to predict the exact magnitude of the Act's effect on employment-based coverage, CBO does expect that as many as 3 million people would lose employer based coverage, noting that "firms that would choose not to offer coverage as a result of the proposal would tend to be smaller employers and employers that predominantly employ lower wage workers."[xiv] Other sources estimate that far more lower-wage employees may be "dropped" into the state exchanges than has been previously estimated—perhaps as many as 43 million, substantially increasing taxpayer obligations and driving up the cost of the program.[xv]

Firms are therefore most likely to end coverage for lower wage employees, and/or outsource or automate their functions to both avoid paying a fine and to shed health insurance costs. In sum, the tax advantage on the exchanges for many households is likely, over the long term, to undermine coverage in the employer-based market, increase taxpayers' exposure to subsidy costs, and reduce demand for low-wage labor.

(Many low-income employees may also find themselves enrolled in Medicaid, a joint-federal state program that offers comprehensive insurance coverage on paper, but which has serious access problems due to low and slow reimbursements for physicians' services. Medicaid also seems to have worse outcomes for serious illnesses like cancer and heart disease.)

One small business owner (an IHOP franchisee in New Jersey) anticipates that Affordable Care Act penalties for his 140 uninsured workers (up to $220,000) will force him to raise prices or possibly lay workers off. "We are still figuring out how to deal with this," he told the Cleveland Plain Dealer in July. "Ultimately, either businesses will close or consumers will pay more."

Regulatory Uncertainty under PPACA Will Hinder Job Creation

The Patient Protection and Affordable Care Act is likely to increase insurance premiums for employers by mandating richer benefit packages; penalize firms that do not offer insurance or do not offer "affordable" insurance; and increase incentives for employers to find ways to reduce insurance coverage for, or reliance on, low-wage labor. Overtime, the Affordable Care Act will significantly undermine the employer-based insurance coverage and leave millions more Americans in insurance markets that are government controlled.

Still, much of the regulation that will affect insurance costs and firms' allocation of wages and employment will be written over the next several years. As a result, employers face tremendous uncertainty as they try to understand their exposure to costs associated with federal and state insurance requirements; calculate potential penalties for going without coverage or exceeding maximum allowable household costs; and prepare to navigate the thicket of regulations that will emerge piecemeal from the Department of Health and Human Services, state departments of insurance, and state health insurance exchanges.

Employers are already struggling with unintended consequences of the legislation. To date, the Department of Health and Human Services has had to issue 733 waivers from minimum insurance requirements under the Affordable Care Act, including 182 issued to plans provided under union collective bargaining agreements.

While HHS should be commended for acting to minimize the loss of coverage or large premium increases for millions of enrollees in these plans, it does underscore the potential for political pressures to be brought to bear that will make the transparent implementation of the Affordable Care Act extraordinarily difficult. Indeed, we have already seen how union pressures on Congress and the White House pushed back the "Cadillac Tax" in the Affordable Care Act to 2018 (and substantially raised the threshold at which the tax takes effect), raising the question of how many other provisions may be selectively enforced or not enforced at all.

At least until 2014, firms will proceed very cautiously before committing themselves to new investment or employment decisions. Given persistently high unemployment, and a fragile recovery from the worst financial crisis since the Great Depression, the Affordable Care Act will remain a drag on the economy until many of these questions are resolved—and beyond. The Congressional Budget Office currently estimates that the Affordable Care Act will reduce labor in the U.S. by approximately .5 percent, primarily because it will "affect some individuals' decisions about whether and how much to work, and some employers' decisions about hiring workers."[xvi]

This may seem to be a modest amount (although it may represent hundreds of thousands of lost jobs). And private firms can and do adapt themselves to a variety of regulatory environments. But a glance at our European competitors shows that universal health insurance is not, in itself, a boost to employment or global competitiveness. Many European countries have persistently higher overall unemployment than the U.S. The French economist Guy Sorman puts it as follows:

France's costly national health insurance is mostly financed by taxes on labor. A Frenchman making a monthly salary of 3,000 euros will pay approximately 350 of them (deducted by his employer) for health insurance. Then the employer will add approximately 1,200 euros, making the total monthly cost to the employer of this individual's services not 3,000 euros but 4,200.

High labor costs in France affect not only consumer prices but also unemployment rates, since employers are reluctant to pay so much for low-skill workers. Economists agree that unemployment rates and the cost of national health insurance are directly related everywhere, which partly explains why even in periods of economic growth, the average French unemployment rate hovers around 10 percent.[xvii]

A different, and better approach for the U.S., would've relied on incremental reforms to expand coverage to those with the greatest medical and financial need; implemented tax reforms to equalize the tax treatment of insurance purchased on the individual market or through employers; and instituted health care and insurance reforms that utilize competition and consumer choice to drive health care costs down.

Instead, we've created a new open-ended federal entitlement, mandated even more expensive, comprehensive insurance coverage, and instituted a massive new regulatory process that will generate unintended consequences for years to come.

Members of the Committee, thank you for the opportunity to be here today. I look forward to answering your questions.

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Chairman KLINE. Thank you, Dr. Howard.

Ms. Johnson?

STATEMENT OF GAIL JOHNSON, PRESIDENT AND CEO, RAINBOW STATION, INC.

Ms. JOHNSON. Good morning, Chairman Kline, Ranking Member Miller and the rest of the committee. I am delighted to be able to speak with you today and grateful for the opportunity to discuss some of the ramifications of the new health care law facing employers and the workforce. In my remarks today, I will share my experience as an employer purchasing insurance coverage for our teachers and staff under the Affordable Care Act.

While this law includes important insurance reforms and increased coverage to many more people, taken as a whole, the law is biased towards mandating coverage rather than providing meaningful cost control. Over the next 3 years, it will force employers to decide between absorbing rising premiums versus paying tax penalties. This will ultimately slow or stall the growth of small and mid-sized businesses as we struggle with the new cost requirements.

Throughout my career, I have focused on women's and children's issues and founded a business, as mentioned before, focusing on quality early education school-age recreation and mildly ill backup care, backup care that provides on each of our Rainbow Station campuses about a thousand productive work days for parents who would otherwise have to stay home with an ill child. We do impact the economy with our business.

As a pediatric and small-business owner, I strongly support the reform of our health care system. It is desperately needed. As a whole, the new law increases access to coverage without controlling costs. Rainbow Station is only beginning to feel the impact of this new law.

Since 1992, we have provided health insurance for faculty and staff. And I have worked diligently to minimize out-of-pocket health care expenses for our employees. I have made a concerted effort each year to keep co-pays low and ensure no deductibles for my staff. I want my employees to access the health care system with minimal financial barriers.

Last month, everything changed. This year, we will insure 84 lives at a cost of $502,000. If I changed nothing and renewed our policy from 2010, our premium would increase 18 percent. This increase would drive my premium to over $593,000. Due to the economic climate of the past 2 years, I just could not afford to absorb this increase and further impact our bottom line.

For similarly-sized workforces, our broker informed us that the baseline increase, or trend, as she called it, is 12 percent per year. This increase encompasses rising insurance costs due to advances in technology as well as rising medical, pharmaceutical and legal costs throughout the insurance, health care industry.

Additionally, our broker informed us that 3 to 5 percent of our scheduled increase was a result of the new mandates and administrative costs caused by the Affordable Care Act of this year. I had hoped that this law would indeed help my premiums to lower, when, in fact, sadly, it did not.

To avoid this premium increase, I made the difficult decision to add an employee deductible of $500. For the first time in our nearly 20-year history, our employees will now pay a deductible. Their premiums will not rise, but we sacrificed our goal of minimizing out-of-pocket expenses and unfortunately, increased a financial barrier to accessing health care services.

This change resulted in forfeiting our ability to grandfather our plan. Moving forward, our plan must now comply with all the mandates required by the Affordable Care Act each year as the law is implemented.

For example, my policy now has—will have to have no dollar limits on durable medical equipment. I employ young teachers, fortunately, healthy, young teachers. They do not have a need for durable medical equipment. But because I now have to include this in my policy, it's causing my premium to increase.

To help keep up with these essential benefits, we will have to eventually pass on to employee—increase our employee cost sharing. The law has transformed health insurance into an obligation rather than a benefit that I can use to supplement salary and attract and retain quality faculty and staff. In the future, I will have even harder decisions to make.

Do I continue to provide insurance coverage to my teachers? Or do I drop insurance coverage altogether and just pay a penalty? The penalty may cost me anywhere from $168,000 to $252,000. Choosing to forego providing insurance coverage could, indeed, save Rainbow Station about $300,000. But at what price?

Will I be able to retain and attract the highest quality early child educators and nurses and staff without providing a quality benefits package? If compelled to eliminate our insurance coverage, I worry what my employees will face in the individual marketplace. There is great uncertainty out there regarding the availability of afford-

able, quality insurance products for our employees in the exchanges.

The situation is more unsettling when considered that many businesses just like mine are facing the same decision. The decision to offer health insurance will strictly be about costs: rising insurance premiums versus tax penalties. Therefore, I fear more employers will choose to drop coverage and instead, pay the tax penalties.

I believe the new health care law will discourage economic growth among small and mid-sized companies. Our government should be encouraging job growth and recovery. But this law disincentivizes for higher wages, new hiring and robust employee benefits. Employers will be compelled to devote more capital resources towards operating costs rather than investing in jobs growth.

Thank you so much for the opportunity to speak with you today. And I look forward to any questions you may have.

[The statement of Ms. Johnson follows:]

Prepared Statement of Gail Johnson, President/CEO, Rainbow Station, Inc.

Good morning Chairman Kline, Ranking Member Miller and members of the committee. My name is Gail Johnson, and I am grateful for the opportunity to address some of the ramifications of the new health care law facing employers and the workforce.

In my remarks today, I will share my experience as an employer purchasing insurance coverage for our teachers and staff now that the Patient Protection & Affordable Care Act (PPACA) is the law of the land. While this law includes important insurance reforms that increase access to coverage for many more people, taken as a whole, the law is biased toward mandating coverage rather than providing meaningful cost control. Over the next three years, it will force employers to decide between absorbing rising premiums versus paying tax penalties. This will ultimately slow or stall the growth of small and midsized businesses as we struggle with the costly new requirements.

Throughout my career, I have been focused on women and children's health and education issues. Before becoming an entrepreneur, I worked as a pediatric nurse for nearly 25 years. As a nurse, I held many roles, including visiting public health and home healthcare nurse; maternity, pediatric and nursery staff; Lamaze instructor; and faculty member of the Maternal Child Nursing Departments at the Medical College of Virginia (MCV)/Virginia Commonwealth University (VCU) and J. Sergeant Reynolds Community College. I continue to be engaged with the MCV/VCU School of Nursing as the Chair of the Nursing Advancement Council and serve as Vice President, Medical College of Virginia Foundation Board of Trustees.

I am the founder and CEO of Rainbow Station, Inc., a nationally accredited preschool and school-age recreation franchise that offers emergency backup care for mildly ill children on site. We provide developmentally appropriate early education and school-age recreation to 325 children on each campus. There are three corporately owned Rainbow Station campuses in Richmond, Virginia. In 1999, I created PRISM, the franchising company for Rainbow Station, and there are currently franchises operating in Virginia, North Carolina and Texas. All Rainbow Station schools are accredited by the National Academy of Early Childhood Programs and/or the National Afterschool Association's Council on Accreditation as soon as they become eligible for accreditation. Some schools are accredited by the Southern Association of Colleges & Schools.

My corporate Rainbow Station campuses employ 225 employees with annual wages for teachers ranging from $23,000 to $35,000. Currently, there are a total of nine schools open, with a capacity for 3,131 children. Fully enrolled, each campus will generate $2.5–$3.5 million in revenue annually, depending on geographic location. There are eight additional locations in development, along with several sales pending.

Within Rainbow Station facilities, we have the capacity to provide backup care for mildly ill children. This care is overseen by a pediatric nurse and results in approximately 1,000 productive workdays each year at each Rainbow Station campus being returned to parents and their employers. We provide these parents with the option to leave their child with a nurse, if they choose to go to work. Rainbow Station pro-

vides flexibility to working parents who would normally be forced to miss work in order to stay home with a mildly ill child. Using the franchise business model, we hope to continue growth and provide these work/family support solutions and services to more communities across the United States. Unfortunately, growth of our business is being significantly challenged by a lack of access to credit and the uncertainty created by the Patient Protection and Affordable Care Act (PPACA).

My franchise system is an active member of the International Franchise Association (IFA). As the largest and oldest franchising trade group, the IFA's mission is to safeguard the business environment for franchising worldwide. IFA represents more than 90 industries, including more than 11,000 franchisee, 1,100 franchisor and 500 supplier members nationwide. According to a study conducted for the IFA Educational Foundation, there are more than 800,000 franchised establishments in the U.S., creating 18 million American jobs and generating $2.1 trillion in economic output.

The findings of the study, Small Business Lending Matrix and Analysis, prepared for the IFA Educational Foundation, support the notion that meaningful economic recovery and meaningful job creation will start with small business lending. In fact, the study determined that for every $1 million in new small business lending, the franchise business sector would create 40.4 jobs and generate $4.2 million in economic output.

Franchised businesses play an important role in the economic health of the U.S. economy, and they are poised to help lead the economy on the path to recovery. IFA Educational Foundation reports show that the franchise industry consistently outperforms the non-franchised business sector, creating more jobs and economic activity in local communities across the country. Franchising grew at a faster pace than many other sectors of the economy from 2001 to 2005, expanding by more than 18 percent. During this time, franchise business output increased 40 percent compared to 26 percent for all businesses.

The IFA continues to seek solutions to ensure that health insurance is more affordable for franchised businesses and their employees. We support proposals that strengthen consumer-oriented, affordable health insurance options and promote small business health plan legislation. Such legislation will allow owners of franchise businesses to pool together across state lines and purchase affordable health coverage. We also support medical liability reform that focuses on reducing litigation that has lead to higher costs. Unfortunately, the legislation signed into law last year contains a framework that will encourage further shifting of health costs onto the backs of small franchised businesses—in the form of a mandate on employers—and impose new taxes and fees that will be passed along by health insurance providers to consumers.

As a pediatric nurse and small business owner, I understand the need for health care reform. However, increasing access to health coverage and forsaking measures to control health care costs will lead to negative repercussions in the small business community. Franchising encompasses businesses of all sizes, from small single unit locations to multi-unit international brands. Systems such as mine—fast-growing, midsized businesses—are the country's strongest job creators. Small and midsized businesses that are growing are able to do so by reinvesting income from their operations to expand. These businesses have limited margins for increased labor and operating costs. Complying with the requirements of the new law will force entrepreneurs to invest less into growing their business. I am here today to inform the Committee on Education and the Workforce that the new health care reform law will slow or stall the growth of small and midsized businesses as we struggle to absorb its new costs.

Several aspects of the new law will add costs and regulatory burdens for small business owners. It establishes an employer mandate to provide health insurance coverage to employees. If employers do not purchase coverage, they will be subject to a penalty of $2,000 per full-time worker. The law further restricts workplace flexibility by defining a full-time employee as one who works at least a four day per week schedule. Furthermore, small businesses will now be required to calculate on a monthly basis the variable schedules of hourly employees to determine requirements under the new law and the associated penalties.

Congress empowered the federal bureaucracy to determine an "essential benefits package," ultimately requiring employers to contribute toward a package they otherwise may not have been able to afford. As crafted, I believe the new law will eliminate all flexibility for employers to design an affordable benefits package. This inflexible, one-size-fits-all approach betrays a bias toward mandating coverage rather than curbing costs. This represents a significant government intrusion into the benefits decisions of employers. In order to comply, small employers will be faced with decisions such as cutting back wages, forgoing new hiring and raising prices for

services. These measures will further stunt any economic recovery and curtail future job growth.

The new law took care to provide exemptions only to certain businesses—those employing less than 50 full-time equivalent employees—this creates a disincentive to hire or expand beyond this level. As is the case of my business, it plants the cost of compliance squarely on the backs of small and midsized firms employing more than 50 people. It is important to note that in a business like Rainbow Station, we must adhere to required ratios of faculty to children in order to maintain state licensure as well as to earn and maintain national accreditation. The only option my business would have to avoid the employer mandate is to cut back on enrollment; and, therefore, services to the community.

Under the new law, starting in 2014, we will be required to offer coverage or pay a tax penalty. To keep up with the law's mandated essential benefits, we will have to increase the amount of employee cost-sharing. This will drive our health insurance costs higher than we are able to provide today. We also must be mindful that our employee's share of the plan does not exceed 9.5 percent of their household income. Otherwise, they will be eligible for subsidies and would trigger penalties of up to $3,000 per employee who receives a subsidy. How are employers supposed to determine the household income of each employee? This is private information that employees would certainly not expect their employers to ascertain in most cases.

The new law emphasizes access to coverage over curbing rising health care costs. The federal government has forced the hands of employers and transformed health insurance into an obligation, rather than a benefit of employment, a benefit that I use to supplement salary and wages in order to attract and retain quality faculty and staff. Essentially, the decision to offer health insurance coverage will strictly be about cost—insurance premiums versus tax penalties. Health insurance coverage will cease being a benefit of employment or part of a competitive compensation package.

Rainbow Station is already beginning to feel the impact of the new health care law. Since 1992, Rainbow Station has provided health insurance for faculty and staff. Because we are a preschool with relatively low wages—although, I am proud to report that our wages are in the upper quartile for our industry—I have worked diligently to minimize out of pocket healthcare expenses for my teachers and staff. Currently we pay 70 percent of the insurance premium for our faculty and staff. I make a concerted effort each year to keep employee co-pays low and ensure no deductibles. I want my employees to be able to access the health care system with minimal financial barriers.

Having just completed the renewal process for our insurance policy, I would like to share with the Committee one example of what small and medium-sized employers are struggling with across the United States. If I did nothing and just renewed our policy from 2010, I would face a premium increase of 18 percent. Our insurance broker informed us that the annual trend increase is 12 percent, and businesses with insurance plans and employee pools similar to our business can expect a 12 percent increase each year moving forward. That increase encompasses continually rising insurance, technology, medical, pharmacy and legal costs across the entire health care industry. An additional 3 to 5 percent of the increase is attributed to the new mandates and administrative costs caused by PPACA that are effective in 2011.

Last month, everything changed. This year we will insure 84 lives at a cost of approximately $502,000. The 18 percent increase would have driven the cost of my premiums to nearly $593,000. Due to the economic climate of the past two years, unfortunately, I could not afford to absorb this increase to our bottom line. Therefore, my choices were to either pass this cost on to my teachers and staff or make changes to the plan. Specifically, we chose to add an employee deductible of $500 to keep our insurance premium costs nearly flat and so our employees' premium will also not rise. For the first time in our nearly 20 year history, our employees will pay a deductible for their health care. We have sacrificed one of our goals in providing employee benefits by unfortunately increasing a financial barrier to accessing health care services.

This change resulted in forfeiting our ability to "grandfather" our health insurance plan. Moving forward, our plan must comply with all of the mandates required by PPACA each year as the law is implemented. While the Administration provided some flexibility to its initial grandfather rules—by allowing small businesses to shop for comparable coverage from different carriers—there remain many hurdles to successfully keeping the health plan our employees like. In the future I will have even harder choices to make. Our insurance plan must now comply with new requirements. For example, my policy must have no dollar limits on durable medical equipment. The majority of my teachers and staff are young females. Traditionally, the

demographics of my workforce allowed me to avoid the higher cost of a plan that had no limits on durable medical equipment. The new law prevents me from purchasing a policy that meets the specific health care needs of my workforce. This will continue to drive up our costs each year. My young faculty and staff, thankfully, are healthy adults that do not need wheelchairs, oxygen tents or catheters. I am being compelled to purchase an expensive policy that provides coverage for medical care my workforce does not require.

In January 2014, I will have a very difficult decision to make. Do I continue to provide insurance coverage to my teachers and staff or drop coverage altogether and pay the penalty? The penalty would cost me anywhere from $168,000 to $252,000 per year and is dependent upon how many of my staff enter the exchange to purchase insurance and qualify for subsidies. Choosing to forego providing health insurance coverage to my employees may "save" Rainbow Station's bottom line as much as $300,000. Will I be able to retain and attract the highest quality early-childhood educators, nurses and staff without providing a competitive employee benefits package?

I am also concerned that if we are compelled to eliminate our health insurance coverage, what will my employees face in the individual marketplace? There is great uncertainty regarding how the exchanges will function and the quality of insurance products our employees will find available to purchase. Furthermore, the situation is even more unsettling when you think about how many other franchisees and small businesses across the country reach the conclusion that their business will no longer be economically viable due to the rising cost of insurance coverage. Unfortunately, more businesses will drop coverage and try to "save" money by instead paying the tax penalty.

Supporters of the law point to the small business tax credit as a benefit for some employers, but the tax credit is entirely inadequate. For a growing company like ours, which provides an important service to the community, the thresholds are entirely too small to be of any assistance. In order to qualify for the tax credit, we would have to cut hours for our full-time staff to ensure we were under the 25 full-time equivalent employee threshold. As I noted earlier in my statement, Rainbow Station must adhere to state mandated staff to children ratios. There is not much we could do to meet the requirements of the tax credit. Encouraging companies to cut back hours or eliminate staff is the wrong message our government should be sending small businesses—particularly during a recession. It is clear that the tax credit is too narrowly restricted to be of any benefit to small businesses.

As I review the new health care law I see a structure designed to discourage economic growth among small and midsized companies. At a time when our government should be doing everything in its power to encourage job growth and recovery, I see a federal requirement that creates disincentives for higher wages, new hiring and robust employee benefits. This law will direct my business decisions in such a way that forces me to devote more of our capital investment resources toward operating costs rather than growth.

I want to thank the members of the Committee on Education and the Workforce for the opportunity to participate in today's important hearing on the effects of the health care law on employers. It is my hope that we can work together to fix the unworkable aspects of the new law that will harm our economy. Moving forward I would encourage Congress to pass legislation that balances the need to improve access to coverage together with controlling the rising costs of care. We must enact new legislation that incentivizes consumer-oriented solutions to health insurance and finally enable my franchise system to band together across state lines to purchase affordable coverage for our employees.

Thank you and I look forward to answering any questions you may have.

Chairman KLINE. Thank you very much.
Dr. Van de Water?

STATEMENT OF PAUL N. VAN DE WATER, SENIOR FELLOW, CENTER ON BUDGET AND POLICY PRIORITIES

Mr. VAN DE WATER. Mr. Chairman, Mr. Miller and members of the committee, I appreciate the invitation to appear before you today. My testimony draws on a letter that I and over 250 other economists recently submitted to the committee.

The Affordable Care Act will significantly strengthen our nation's economy over the long haul. The law takes essential steps to slow the growth of health care costs, which are consuming an ever-increasing share of our economic output. And it contributes to the stagnation in workers' real wages.

The Congressional Budget Office estimates that health reform will slightly reduce premiums for employer-sponsored health insurance in the near-term. For employers with more than 50 workers who account for 70 percent of the total insurance market, CBO estimates that the law will reduce average premiums by up to 3 percent in 2016. Small business will pay less for a given package of benefits. Qualified small businesses are also eligible for federal tax credits for their health insurance contributions.

Even if health reform were to impose some costs on employers, economic principles strongly suggest that the impact on business hiring decisions would be small. Because the major impact of health reform does not begin until 2014, businesses will have time to adjust, increasing the likelihood that any impact will be primarily on workers' after-tax compensation, not on hiring. And in the following years, as health reform begins to slow the growth of health care costs, workers will see larger increases in their take-home pay.

All in all, the short-term economic effects of health reform will be quite small. One major financial research firm termed the law's economic impact minor and said, "any disincentives from higher taxes and fees will hardly make a difference."

CBO foresees a small net reduction in labor supply because some people who now work mainly because they need to obtain health insurance will choose to retire earlier or work somewhat less, not because employers will eliminate jobs. Over the long haul, health reform will have many positive effects on the economy.

First, CBO estimates that health reform will reduce the budget deficit, modestly in the first decade, but substantially thereafter. The lower budget deficits stemming from health reform will hold down interest rates, free up more capital for private investments and boost long-term economic growth.

Second, health reform will increase labor markets' flexibility. The new law will reduce job loss when workers stay in the job just because they are afraid of losing their health insurance. As a result, Americans will be more able to switch jobs and open new businesses. The result will be a more productive economy.

Third, expanding health coverage to 32 million uninsured people will improve health outcomes by helping people obtain preventive and other health services and improving continuity of care. This, too, will enhance economic productivity.

Finally and most important, the Affordable Care Act contains almost every cost-containment provision that policy analysts have considered effective in reducing the growth of medical spending. These include payment innovations that will reward providers based on the value of their care and not on the volume of their procedures, an excise tax on high-cost insurance plans, independent payment advisory board, a center for Medicare and Medicaid innovation, measures to inform patients and payers about the quality

of health care providers, more funding for comparative effectiveness research and steps to promote wellness and prevention.

Slowing the growth of health care costs is one of our nation's most pressing economic challenges. And success will benefit employers, workers and taxpayers. The effort will require an ongoing process of testing, experimentation and rapid implementation of what is found to work. Health reform begins that vital process.

Thank you very much.

[The statement of Mr. Van de Water follows:]

Prepared Statement of Paul N. Van de Water, Senior Fellow, Center on Budget and Policy Priorities

Mr. Chairman, Mr. Miller, and members of the committee, I appreciate the invitation to appear before you today to discuss the impact of health reform on the economy, employers, and the workforce. My testimony draws on a letter that I and over 250 other economists have submitted to the committee (a copy of which is attached).

The Affordable Care Act (ACA) will significantly strengthen our nation's economy over the long haul, although initially its effects will be modest. The law takes essential steps to slow the growth of health care costs, which are consuming an ever-increasing share of our economic output and have contributed significantly to the stagnation in workers' real wages in recent years.

The Congressional Budget Office (CBO) estimates that health reform will slightly reduce premiums for employer-sponsored health insurance in the near term. For employers with more than 50 workers (who account for 70 percent of the total insurance market), CBO estimates that the law will reduce average premiums by up to 3 percent in 2016. For small employers, the estimated change in premiums ranges from an increase of 1 percent to a reduction of 2 percent.[1] Many small businesses will pay less for a given package of benefits and are likely to provide more comprehensive health coverage than they do today. Qualified small businesses are also eligible for federal tax credits for health insurance contributions. The early retiree reinsurance program will provide interim financial relief to employers for the cost of covering retirees between ages 55 and 65.

Even if health reform were to impose some costs on employers, economic principles strongly suggest that the impact on business hiring decisions would be small. Any such effect would instead ultimately be passed on to workers in the form of slower growth in their after-tax compensation. CBO draws that conclusion with respect to both the Affordable Care Act's excise tax on high-cost health insurance plans beginning in 2018 and its penalty on firms with 50 or more employees that do not offer affordable health insurance.[2] And because the major impact of health reform does not begin until 2014, businesses will have time to adjust, increasing the likelihood that any impact will primarily be on employees' after-tax compensation, not on hiring. In the following years, as health reform begins to slow the growth of health care costs, workers will see larger increases in their take-home pay.

All in all, the short-term economic effects of health reform will be quite small. Moody's Analytics terms the law's economic impact "minor" and says that any disincentives from higher taxes and fees "will hardly make a difference."[3] CBO foresees a small net reduction in labor supply, because some people who now work mainly to obtain health insurance will choose to retire earlier or work somewhat less, not because employers will eliminate jobs.[4] That effect could be partly offset, however, by increased incentives to work for people who now face losing Medicaid coverage if they work more.

Over the longer run, the health reform law will have many positive impacts on the economy. First, CBO estimates that health reform will reduce the budget deficit—modestly in its first ten years, but substantially in the following decade.[5] In a letter to Speaker Boehner a few weeks ago, CBO stated that repealing the ACA would add $230 billion to the federal deficit between now and 2021.[6] According to Moody's Analytics, the lower budget deficits stemming from health reform will hold down interest rates, free up more capital for private investment, and potentially boost long-term economic growth.

Second, health reform will increase labor market flexibility. Moody's Analytics also points out that "there is the potential for the new law to reduce 'job lock,' when workers stay in a particular job because they are afraid of losing their insurance. * * * If the bill works as planned, Americans will be more able to switch jobs and open new businesses."[7] As CBO says, "making it easier for some workers to obtain

health insurance outside the workplace * * * enabl[es] workers to take jobs that better match their skills."[8] The result will be a more productive economy.

Third, expanding health coverage to 32 million uninsured people will improve health outcomes by helping people obtain preventive and other health services and improving continuity of care.[9] CBO suggests that this could also enhance the nation's economic productivity.

Finally, and most important, the Affordable Care Act contains almost every cost-containment provision that policy analysts have considered effective in reducing the growth of medical spending. These include:

- Payment innovations, such as bundled payments and accountable care organizations, to reward providers based on the value of their care, not just the volume of their procedures;
- An excise tax on high-cost insurance plans to make consumers more cost-sensitive and discourage excess utilization;
- An Independent Payment Advisory Board that will develop and submit proposals to reduce cost growth and improve quality in both Medicare and the health care system as a whole;
- A Center for Medicare and Medicaid Innovation that will test, evaluate, and foster rapid expansion of new ways to increase the value of care;
- Measures to inform patients and payers about the quality of health care providers;
- Increased funding for comparative effectiveness research; and
- Promoting wellness and prevention.

Slowing the growth of health care costs is one of our nation's most pressing economic challenges, and success will benefit employers, workers, and taxpayers. Health care experts agree that the effort will require an ongoing process of testing, experimentation, and rapid implementation of what is found to work. The health reform law begins that process.

ENDNOTES

[1] Douglas W. Elmendorf, Director, Congressional Budget Office, Letter to the Honorable Evan Bayh, November 30, 2009.
[2] Congressional Budget Office, "Box 2-1: Effects of Recent Health Care Legislation on Labor Markets," The Budget and Economic Outlook: An Update, August 2010, pp.48-49.
[3] Augustine Faucher, "Healthcare Reform Doesn't Alter the Outlook," Moodys' Analytics, March 26, 2010.
[4] CBO, Box 2-1.
[5] James R. Horney and Paul N. Van de Water, Health Reform Will Reduce the Deficit, Center on Budget and Policy Priorities, March 25, 2010, *http://www.cbpp.org/cms/index.cfm?fa=view&id=3134.*
[6] Douglas W. Elmendorf, Director, Congressional Budget Office, Letter to the Honorable John Boehner, January 6, 2011.
[7] Faucher.
[8] CBO, Box 2-1.
[9] Jill Bernstein, Deborah Chollet, and Stephanie Peterson, How Does Insurance Coverage Improve Health Outcomes?, Mathematica Policy Research, April 2010, *http://www.mathematica-mpr.com/publications/PDFs/Health/Reformhealthcare—IB1.pdf.*

Chairman KLINE. Thank you.
Mr. Trautwein?

STATEMENT OF NEIL TRAUTWEIN, VICE PRESIDENT AND EMPLOYEE BENEFITS POLICY COUNSEL, NATIONAL RETAIL FEDERATION

Mr. TRAUTWEIN. Thank you, Mr. Chairman, Ranking Member Miller and honored members of the committee. My name is Neil Trautwein. And I am a vice president with the National Retail Federation.

As I have noted before, the retail community is one of the toughest populations to cover with health insurance. We may, in fact, be the canary in the coalmine when it comes to health insurance coverage.

We have high turnover rates, admitting first-time job holders. We have a high percentage of part-time employees. Stores and res-

taurants often serially share employees. Many otherwise coverage-eligible employees opt out of the coverage we offer.

One common element in the retail industry are our profit margins, which are wafer thin. We have to manage everything in our stores very, very tightly, particularly the cost of labor because we are a labor-intensive industry. And benefits is included in that cost of labor.

In our view, the last Congress' health care reform debate was needlessly divisive. There was a broad consensus for reform that addressed cost savings in the health care system. We proposed—the National Retail Federation proposed a reform platform in 2007 and 2008. We worked very diligently in multi-stakeholder groups to try to reach consensus on reform. We supported reform until it was clear we could no longer support the reform bills in Congress.

We continue to strongly support what we wish you would have started with in the first place, which is job-friendly health care reform that starts with reducing the costs of medical care, which in turn, drives the health care increases in our economy. We supported the repeal and replace efforts in the Congress, not because we have opposed reform, but because we absolutely need it.

The Patient Protection and Affordable Care Act was not what we needed in terms of reform. Passage of health care reform is already complicating life for many retailers today. There is a lot of confusion over the law. And we haven't even gotten to 2014, which is the year that really scares my members. Nevertheless, it remains the law of the land.

We have worked hard to brief our members on both the opportunities under the law and their coming obligations. We have worked with the Obama administration to help smooth the impact of the law wherever possible. We appreciate their efforts to do so.

We are working hard to find and recommend ways to help improve the law and make it work better. First and foremost, we urge you to get rid of the employer mandate penalties for failure to offer coverage, to failure to offer affordable coverage based on family income and the so-called free choice vouchers in the law.

Ironically, it may prove less expensive for many employers to stop offering coverage than to continue to offer that coverage under the law. For example, an employer with 52 full-time employees would pay, according to Kaiser Family Foundation estimates, between $520,000 and $780,000 to cover their workforce. It could also additional penalties based on family income for unaffordable coverage.

The same employer would pay a penalty amount for not covering those 52 employers of $44,000 under PPACA. While the difference between $780,000, $520,000 and $44,000 is pretty substantial, it may not be enough of itself for employers to make that decision. There are other factors that come to play in terms of offering benefits or not. But nevertheless, this factor is significant by any business measure.

NRF has created a health care mandate cost calculator on our Web site. It is freely available. We take no data from that. And no password is required. It allows you to model different size businesses and how the mandate penalties potentially will apply.

These mandate penalty provisions are already affecting hiring decisions in today's marketplace. Our members have just come out of recession. If that, people are not fully back in the stores. So, you know, the question of whether to hire or not is particularly difficult for our members right at the moment.

My written testimony contains four case study examples of the effect of PPACA on their workforce. And I encourage their review. I also include several recommendations to add additional flexibility to the law to help employers to continue to make that transition over time.

One additional area I would encourage you to watch. We urge Congress to resist any temptation for the states to look for waivers from PPACA to displace the law in their local areas. There is no quicker way to break the back of employer-based health care, multi-state employers, than to harm ERISA.

Again, I appreciate the chance to appear before you today. And we look forward to working with you to help bring more meaningful health care reform in the future.

Thank you, Mr. Chairman.

[The statement of Mr. Trautwein follows:]

Prepared Statement of Neil Trautwein, Vice President and Employee Benefits Policy Counsel, National Retail Federation

Mr. Chairman, Ranking Member Miller and honored members of the Committee, I thank you for the opportunity to appear before you today and to share our views regarding the new health care reform law—the Patient Protection and Affordable Care Act (PPACA). My name is Neil Trautwein and I am Vice President and Employee Benefits Policy Counsel of the National Retail Federation (NRF).

As the world's largest retail trade association, the National Retail Federation's global membership includes retailers of all sizes, formats and channels of distribution as well as chain restaurants and industry partners from the U.S. and more than 45 countries abroad. In the U.S., NRF represents the breadth and diversity of an industry with more than 1.6 million American companies that employ nearly 25 million workers and generated 2010 sales of $2.4 trillion.

The retail industry has one of the hardest workforces of any to cover with health insurance. We have a fairly young workforce (but also have a growing senior cohort) coupled with a high turnover rate. We employ half of all teenagers in the workforce and a third of all workers under 24 years old. More than a third of our workforce is part-time. Two-thirds of our part-time employees are women. Frequently, qualified retail workers opt-out of the coverage we offer because they already have alternative coverage through another family member or another job. Many are second wage earners, mainstays of family economies. Smaller retailers often experience problems making health insurance plan participation requirements because too many employees opt out.

As a labor-intensive industry, retailers are strong advocates of high quality and affordable health coverage in order to help keep our employees healthy and productive. In fact, a retailer (Montgomery Ward) was one of the first businesses to offer medical coverage in the U.S. As an industry that frequently endures wafer-thin profit margins or worse, we are also well acquainted with the need to manage the collective cost of labor (including benefits) in as cost-effective a manner as is possible. Maintaining balance between these two imperatives is not always easy. Even in the best of times, it can border on the impossible—and these are still far from being the best of times.

The previous Congress' health care reform debate was highly and, in our view, unnecessarily divisive. The retail industry proposed in 2008 and strongly supported comprehensive health care reform (see NRF's Vision for Health Care Reform, www.nrf.com/healthcare) that would reduce health care costs and extend coverage to the uninsured. We proposed building from the voluntary base of coverage by lowering the cost of medical care and coverage in order to extend coverage to those without. I testified before this Committee's Subcommittee on Health, Employment, Labor and Pensions in March 2009 to share our reform platform.

Instead, Congress enacted—over our strong objections—a reform law that fails to quickly reduce health care and coverage costs. It will also impose unwarranted penalty mandates on employers in 2014 that are already deterring job growth today. NRF strongly opposed both the House and Senate-passed reform bills and the modified Senate bill that became law.

We continue to oppose this law today. NRF supported the successful passage of H.R. 2 in the House on January 19, 2011. NRF also supported the unsuccessful repeal vote in the Senate on February 2, 2011. We took these actions not because we oppose reform, but because we absolutely must have it. Unfortunately, rather than moving us forward, passage of PPACA has made providing coverage more difficult for today's retailer.

Nevertheless, PPACA remains the law of the land. NRF has worked hard to alert our members to the staged implementation of PPACA and increasing employer obligations under the law. We have also worked to identify and suggest improvements. We have worked closely and cooperatively with the Obama Administration wherever possible to help smooth implementation of the law. We continue to work with the Administration to flesh out missing or contradictory provisions of PPACA, especially as regards the penalty mandate provisions effective in 2014.

We strongly support what we needed to start with in the first place: more job-friendly health care reform that will concentrate first on reducing the cost of medical care. Toward that end, we also support efforts like H.R. 4, which that would repeal the expanded Form 1099 reporting requirements under PPACA.

Requiring reporting for all non-credit card transactions over $600 in a year will create a blizzard of reports that will needlessly bog down commerce while also swamping the IRS. This provision has no relevance to our health care system and should be promptly repealed. This necessary change to PPACA rightly enjoys broad bipartisan support—and received an overwhelming Senate vote of 81-17 February 2, 2011 on a dispositive procedural motion. We look forward to its prompt approval in the House as well.

Employer Penalty Mandate

The PPACA penalty mandates effective in 2014 differ from more traditional employer mandates by not directly mandating the provision of coverage. Instead, it penalizes the failure to do so for full time employees, defined as working 30 or more hours per week. Employees with fewer than 30 hours per week are not counted for penalty purposes, though their hours are aggregated to determine whether an employer meets the 50 full-time equivalent employee threshold for coverage. Employers with fewer than 50 full-time equivalent employees are exempt.

PPACA also penalizes an employer who provides coverage to full-time employees if the cost to an employee exceeds 9.5 percent of his or her family income. The penalty for failure to provide coverage to full-time workers is $2,000 per uncovered full-time employee minus the first 30 full-time employees. The penalty for providing "unaffordable coverage" to a full-time employee is $3,000 for each full-time employee with unaffordable coverage, up to a cap of $2,000 times every full-time employee, minus the first 30.

Ironically, it may prove less expensive for many employers (including some public employers) to pay the penalty than to pay for coverage and any possible penalties for "unaffordable care." For example, an employer with 52 full-time employees would pay an average of $520,000 to $780,000 for coverage (based on Kaiser Family Foundation estimates). The employer could also owe penalty amounts as noted above for the failure to provide affordable coverage even though he or she is providing the same coverage to all employees. That same employer would owe a penalty for failure to provide any coverage to full time employees of $44,000 (52 employees minus the first 30 times $2,000).

While the substantial difference between coverage cost and penalty amounts is not dispositive in itself—other considerations will factor into each employer's determination—it certainly is significant by any measure. PPACA may thus ultimately succeed in dismantling employer-based health coverage. We strongly urge repeal of the employer penalty mandate provisions.

Many retailers have been astounded by the prospect of being penalized for providing coverage that exceeds a factor largely beyond their knowledge or control: an employee's family income. They have also been shocked by the "free-choice" vouchers in which certain low-income employees can opt out of the employer plan taking their employer's contribution with them in the form of a voucher. Employer costs could greatly increase as younger, healthier entry level employees opt out. Finally, retailers of all sizes oppose shifting our health care system from voluntary to mandatory through penalty mandates.

NRF has created a special web-based Health Mandate Cost Calculator to help illustrate the penalty mandates to various sized employers. The NRF Calculator is intended to be an open modeling tool and no data is collected from it. I attach several screen prints of the calculator in action at the end of this statement. I also encourage the members of this Committee, their staff and the general public to see it in action for themselves at www.nrf.com/healthcare. No password is required.

Effect on the Retail Community

The penalty mandate provisions are already affecting hiring decisions in advance of their effective date in 2014. We have heard reports from across the retail community (including our restaurant members) that the penalty mandates are affecting expansion, franchising and hiring decisions today. We respectfully urge Congress to reassess and repeal the penalty mandate to help encourage needed growth in jobs and our economy.

We collected a number of examples from our chain restaurant division (National Council of Chain Restaurants) in late 2010. Please note the four examples below:

Example 1

One of the nation's largest quick service restaurant (QSR) chains has estimated the incremental cost to comply with the new health care law to be $10,000 to $15,000 annually per restaurant. Across this chain's entire franchised system, that would equate to $50 to $75 million in incremental costs, annually. These costs would wipe out up to one-third of this system's profits per year, potentially causing hundreds of restaurants in the system to go out of business, eliminating up to 12,500 jobs.

Most of the restaurants in this chain's system are locally-owned and operated by small business franchisees. These franchisees typically own just a handful of restaurants, and these new costs could cause them to lose some or all of their stores. The reasons are two-fold.

First, there are limited options for restaurants in this chain to try and offset these dramatic new costs. In this economy and competitive environment, raising prices has not been an option (although higher prices may ultimately result economy-wide given the game-changing nature of this law). Second, laying off employees to reduce costs is also not an option because these stores already keep a minimum number of hourly team members on the clock as required to best serve customers. Some of the restaurant owners in this system may consider dramatically lowering each full-time team member's weekly hours to less than 30 hours in order to avoid full-time classification.

The only option left for many restaurants in this system will be to close their doors. In fact, this chain projects that 10 percent of its small business franchisee owners will not be able to absorb the new costs of the health care law and will shut down restaurants. Each restaurant employs between 12 and 25 team members. In a system with 5,000 restaurants, the loss of 500 restaurants translates into a loss of between 6,000 and 12,500 jobs.

Example 2

A second chain—a large franchised system with multiple casual/family dining restaurant concepts—projects that the average cost per restaurant in their system would be $237,000. That equates to a system-wide cost of providing health insurance benefits to full time employees of almost $806 million per year. If all of the chain's small business franchisee owners elected to pay the employer penalty instead of providing insurance, the cost would be reduced to just over $84,000 per restaurant, or a savings of $286 million system-wide.

As each restaurant in this system is owned and operated by an individual small business person, it is impossible to predict how each would react to such dramatic cost increases. To cope with these cost increases, these owners could reduce the number of employees per restaurant, reduce the number of hours worked, or reduce the number of full time employees and rely on more part time labor.

If every franchisee reduces the number of full time employees to the bare minimum required, over 100,000 employees who are currently full time would be shifted to part time. If the franchisees elected to provide health insurance benefits to the remaining full time employees, the cost per restaurant would be $69,000 (versus $237,000 per restaurant with the existing number of full time workers). The cost savings under this scenario would be $571 million system-wide. However, if the franchisees elected instead to just pay the employer penalty for the remaining full time employees under the skeleton crew scenario, the cost per restaurant would be $24,470, or just over $83 million system-wide.

Example 3

Another casual dining chain, also franchised, currently offers all its employees, regardless of hours worked, limited benefits health insurance plans that cost employees as little as $1 a day. The chain spends almost $9 million a year on this plan. Under the new health care law, this company anticipates it will reduce the number of jobs it offers by 15 to 23 percent, or 5,000 to 8,000 jobs.

The choices, as this chain sees it, are three-fold. It could choose not to provide insurance to full time employees and simply pay the penalty, which would cost $56 million per year. This figure exceeds this company's profit last year by almost $11 million. Or, it could keep its current number of full time and part time employees and provide insurance, which would cost the system over $27 million annually. This cost would consume 42 percent of last year's profits.

Finally, the company could reduce the number of full time employees and eliminate the benefits that are currently offered to part time employees, which is an unattractive option because it could result in higher turnover and higher training costs. This company believes all three options are unattractive, and that the most rational choice for them is to maintain its reliance on a workforce that is primarily full time, but to reduce the number of jobs overall by between 5,000 and 8,000.

Example 4

A mid-sized quick service restaurant chain that employs nearly 60,000 workers does not believe that the health care law is economically feasible. This chain owns and operates approximately 1,100 restaurants, and their independent franchise owners operate an additional 1,100. They currently offer health insurance to all employees, including restaurant crew members who are offered a range of coverage options including a limited benefit "mini-med" plan.

This chain has carefully reviewed the requirements placed upon employers in the new healthcare law, and has worked with their insurance brokers and actuaries to determine what the potential cost of compliance might be. They are disappointed that more cost control measures were not included in the law, and that no consideration was given to the possibility that some employers might continue to offer limited benefit plans to hourly workers.

They believe the cost associated with offering the full benefit health insurance plans that the law requires is excessive, and they do not believe that they will be able to offer such coverage to all workers. They are analyzing many options as they prepare to comply with the law, including the possibility that many of their restaurant employees that would currently qualify as full-time workers might see a reduction in their hours of work such that they would be considered part-time workers.

Priority Workforce Changes to PPACA

I have previously noted the harmful workforce effects of PPACA compliance. Central to these concerns is the lack of flexibility that will constrain retail's ability to manage our high turnover rate. I note that many states have expressed similar concerns over the lack of flexibility under PPACA, most recently expressed in a February 7, 2011 letter to Secretary Sebelius from 21 Governors.

Our preference would be for an outright repeal of PPACA to be replaced by legislation that places top priority on reducing the cost of medical care and coverage. Short of that, we advocate the following initial nonpartisan steps to help expand employer flexibility and to help lower the cost of providing coverage:

1. Repeal employer mandate penalties, including the penalties for providing "unaffordable" coverage and the "free-choice" vouchers.
2. Define a full-time employee as working 40 hours per week, determined on at least a 120-day basis.
3. Expand waiting periods to at least 120 days.
4. Repeal auto-enrollment or delay onset of auto-enrollment for at least 120 days, consistent with maximum waiting periods.

ERISA

Given this Committee's jurisdiction, we would be greatly remiss in not mentioning our continued strong support for ERISA. ERISA allows employers to offer common coverage across state boundaries—an ability crucial to multi-state employers. We strongly oppose any effort to weaken ERISA's preemption of inconsistent state laws for health plans (also known as welfare plans under ERISA).

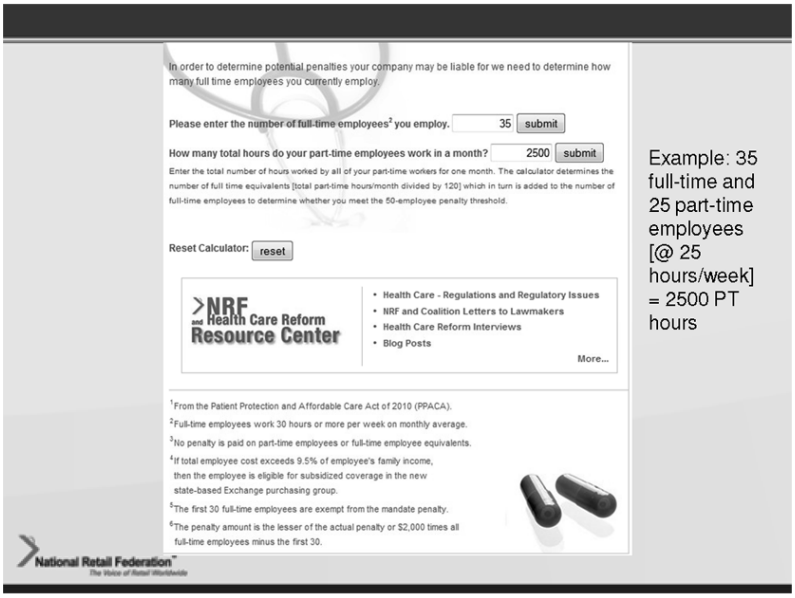
We urge Congress to resist any entreaties by the states to waive ERISA preemption in favor of a competing state reform scheme. We cannot afford to dismantle the backbone ERISA provides to employer-based coverage. ERISA has worked well and continues to work well to help provide coverage to millions of working Americans.

NRF continues to believe in addition that smaller employers could also benefit from ERISA preemption through small business health plans or association health plans.

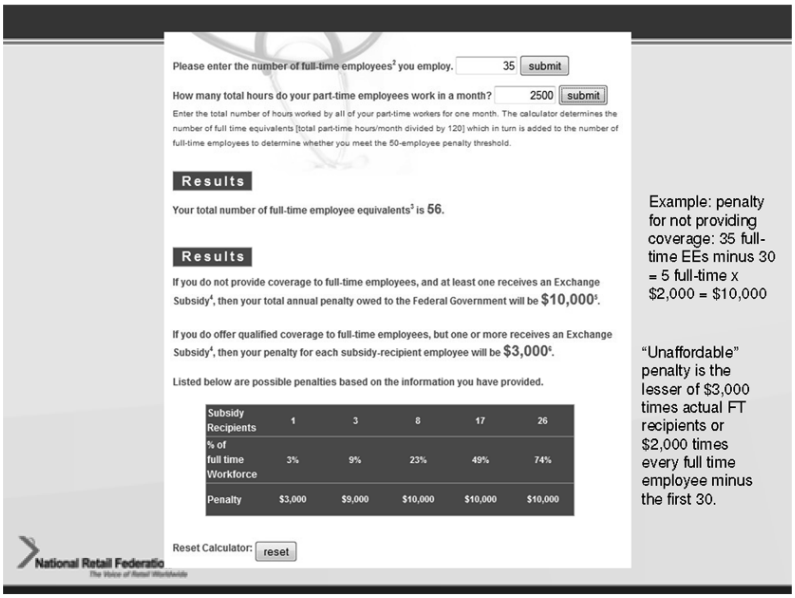
Conclusion

Again, NRF greatly appreciates the opportunity to appear before you today. In sum, we urge you to work to create a value-oriented health care system that promotes lower cost and higher quality care and coverage for employers of all sizes and individuals from all walks of life. That will require stepping away from PPACA—either through repeal, as the House has done, or through wholesale change to PPACA, especially as regards the penalty mandates. We look forward to working with you to help promote the enactment of positive health care reform.

Attachment (A)

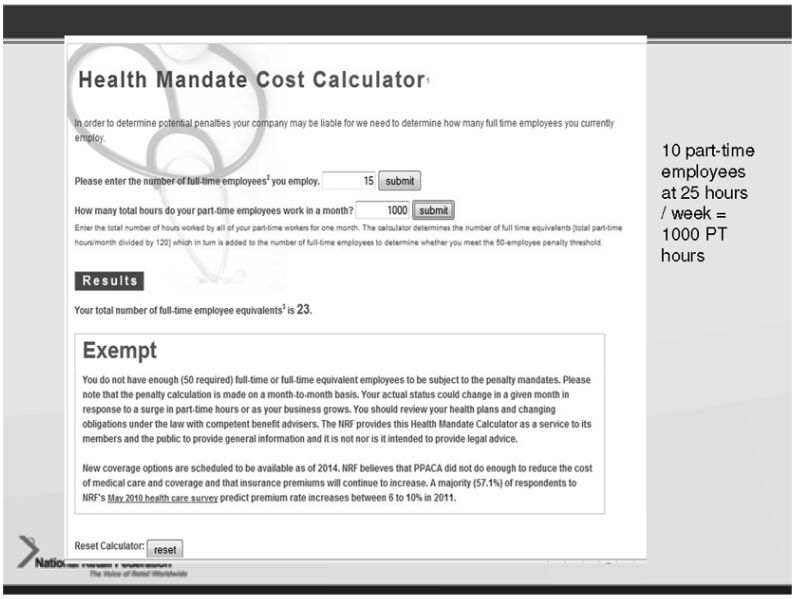


Example: 35 full-time and 25 part-time employees [@ 25 hours/week] = 2500 PT hours

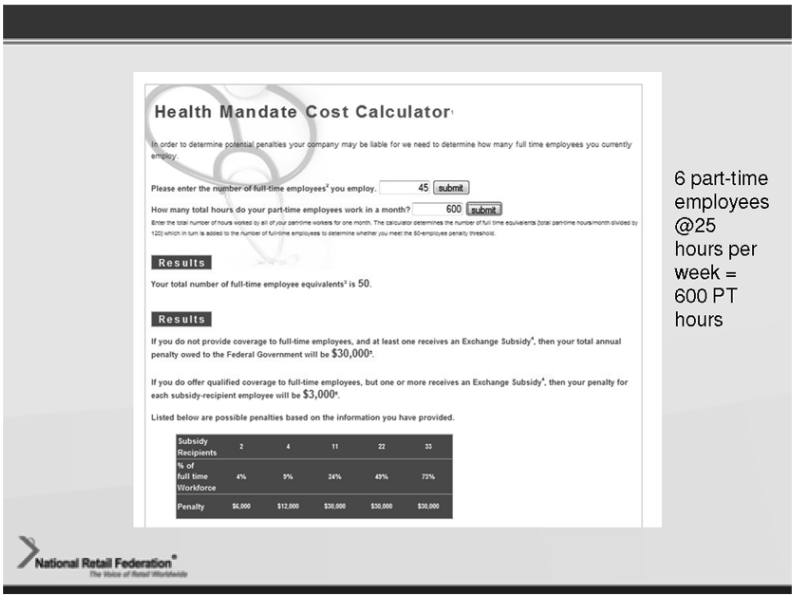


Example: penalty for not providing coverage: 35 full-time EEs minus 30 = 5 full-time x $2,000 = $10,000

"Unaffordable" penalty is the lesser of $3,000 times actual FT recipients or $2,000 times every full time employee minus the first 30.



10 part-time employees at 25 hours / week = 1000 PT hours



6 part-time employees @25 hours per week = 600 PT hours

The cost for single coverage [$10K - $15K] would run to $50-75 million.

Chairman KLINE. Thank you.
I thank all the witnesses for their testimony.

We will move to member questions now. I am going to put myself on the clock as well. I start off optimistically always. As then we will move through each side and ask questions.

There has been an ongoing debate, and we heard it here today. And I suppose we will continue to hear it, about whether or not this health care law reduces medical costs and health care costs. It has been my understanding, my belief, having listened to many economists, many witnesses that it does not reduce costs. So let me start with Dr. Van de Water.

You are one of those who claim that this law will reduce the growth of medical spending or help reduce costs. Yet, just recently in a presentation to the Institute of Medicine, actually last May, CBO Director Elmendorf concluded that, "Rising health costs will put tremendous pressure on the federal budget during the next few decades and beyond. In CBO's judgment, the health legislation enacted earlier this year does not substantially diminish that pressure."

Do you disagree with——

Mr. VAN DE WATER. [OFF MIKE].

Chairman KLINE. Yes.

Mr. VAN DE WATER. As I stated in my testimony, that controlling health care costs is not a simple, short-run proposition. And certainly, in the near-term, we are not going to see a major change in the cost trend. But as CBO Director Elmendorf has indicated, that the health reform act does contain several important provisions which hold great promise in the longer term for slowing health care cost growth.

And Director Elmendorf, I think, has particularly cited the payment innovations that I mentioned, of the sort that would encourage—that would reward providers, not simply because they do more stuff, because they carry out more procedures, but because the procedures that are done provide more value for money. And secondly, also, but something which doesn't begin for several years and which I know is controversial, but most economists think is a good idea, namely, the excise tax on high-cost health plans, which will discourage the offering of plans which are overly generous and encourage excess use of health care services.

You see the result of all of this in the national health expenditure projections, which the Center for Medicare and Medicaid Services actuary puts out. In the near-term, there will be some very modest increase in total national health spending as we cover 32 million more Americans. But later in the coming decade, the rate of cost growth, according to the Medicare actuary, is projected to slow as the various cost-containment provisions in the Affordable Care Act begin to kick on.

Chairman KLINE. Okay. Thank you.

Dr. Howard, would you care to comment? We will have battling economists here, I am pretty sure.

Mr. HOWARD. I think that the substantial savings that is anticipated by the act in its second decade comes from across-the-board cuts to provider rates under Medicare that the Medicare actuary in a dissent to the 2010 report said were going to be unsustainable because most of the easy productivity gains have already been

taken out of the system. And the actuary estimates that most of those cuts would be repealed. So we are going to lose that money.

I think what we are talking about here is the downside financial risk of taking what is essentially a trillion dollar gamble that, while we don't think that the law is going to reduce spending in the short-term, as a matter of fact, it is going to go up by about $300 billion during the first decade, but in the second decade, we are hoping that some of these other things will kick in. I think that is quite a gamble to take, given the enormous deficit problems the U.S. is already facing.

Chairman KLINE. I am going to continue the—well, I guess I am not going to continue. If I am going to be consistent here in trying to maintain the 5-minute rule—I was going to get into another ongoing debate. And that is the discussion about whether or not this actually reduces the deficit.

And I know that that probably somebody else will get to that. There are a number of factors, one of which that you talked about. And that is Medicare reductions in payments to physicians and so forth, which may very well not occur.

But in order to set the example for my colleague, Mr. Miller, I will yield—you do? I will yield back.

Mr. MILLER. Thank you, Mr. Chairman, very much for the hearing. To continue the discussion you just started, I find it interesting that this discussion started out suggesting that a lot of people were going to not—in the future, not going to offer insurance. And we see the New England Medical Journal telling us that they expect coverage will increase from 84 percent to 94 percent as a result of these reforms. And we see the Rand Corporation estimating that the exchanges will allow small employers to increasingly offer health care coverage because they will have the same purchasing power as large employers.

Currently, there is about an—a 13 percent difference in the cost of those because small employers don't have the ability to organize in that fashion. Rand expects to offer rates to increase for employers with 50 or fewer employees from 57 to 80 percent. So that small employers under 50—it is interesting that that projection is now—we see Forbes and the L.A. Times commenting 2 weeks ago that the insurers are stating that they are covering more employees since the enactment of this act.

The UnitedHealth Group, which, I think, is one of the largest, added 75,000 new customers working in businesses of 50 or fewer employees. Coventry Health added 115,000 new workers in 2010, an 8 percent jump. Blue Cross/Blue Shield in Kansas City reported that—somewhere. I lost my paper here—an increase of 58 percent in the number of small businesses purchasing coverage since April of 2010.

So I appreciate all of the speculation. But the fact of the matter is on the ground, small businesses are starting to extend coverage to their employees at rates we haven't seen in the past.

The question about costs—we have seen a doubling of costs. We have seen more than a doubling of premiums to businesses and to families and to others. And we have had businesses coming to the Capitol for 10 or 15 years telling us that this is crushing them.

And yet, we see the Business Roundtable telling us if we do the things in the act that are, in fact, part of this act, that they would expect by 2019—so if you look at this decade, compared to the previous decade, where it all doubled, that they expect that large employers will save some $3,000 per employee on health care costs by 2019. That is not me. That is the Business Roundtable.

Why did they say that? Because what is, in fact, in this bill is a challenge to the Congress of the United States and to everybody on this committee and every policymaker in the Congress. And that is because in this legislation are the reforms that have been proposed as a matter of cost containment for many years, never accepted by the Congress prior to this, the reforms on bundling, on readmission policy, on accountable care organizations, on strengthening primary care and prevention and wellness.

And we see major organizations on the employer side and on the benefits side of offering the annual checkup, the preventative care for people to try to avoid those health care costs. We are already seeing small improvements in some of the organizations that started with the pilots on readmission policy.

So the fact on the ground is contrary to the political speculation under the dome of the Capitol. Small employers are voting with their dollars. Employees are voting with the desire to have care. And I think one of the most important one is I opened with the testimony of Dr. Odette Cohen. And the fact is that they expect much of this because of the exchanges that go into effect in 2014, where small employers will have the ability to have the same leverage in choosing policies that large employers have today.

So again, the prospects of the actual legislation, not the speculation, the prospects of the actual language, not the speculation, suggest that already institutions of delivery, institutions of insurance, institutions of employers are already adapting and, in fact, expanding health care coverage as the economy recovers. And I appreciate all of the discussion about all of the uncertainties that this has created in the community. And yet, today we see that the survey of small businesses is more confident than any time in recent history, even with this passed of health insurance on the horizon.

So I hope that helps to stimulate the debate for the rest of the morning. Thank you. And I yield back the balance of my time.

Chairman KLINE. I am so impressed. It is just excellent. I thank the gentleman.

Mr. Thompson, you are recognized for 5 minutes.

Mr. THOMPSON. Thank you, Mr. Chairman.

Thanks to the panel for being here and lending their expertise. You know, according to analysis of—backed up by former CBO Director Doug Holtz-Eakin, the health care law, "My strong sense from employers with the agreement of their employees to drop employer-sponsored health insurance for as many as 35 million Americans."

And this is far from being a partisan suggestion. Outgoing Tennessee governor from the state of my colleague sitting next to me, Governor Phil Bredesen, a Democrat, expands on the same perverse incentive in the Wall Street Journal editorial entitled, "Obama-Care's Incentive to Drop Insurance," published in October of 2010.

You know, during the debate over the health care reform last year, there were a lot of promises made. One, that health insurance costs would decrease. But according to CBO analysis, individual health insurance payments will rise by an average of $2,100 per family.

And this increase comes despite President Obama's frequent promises that his health care plan would lower premiums by $2,500 per year for an average family. And, two, another promise of many, if you like your health care plan, you can keep your health care plan, despite indications that insurance companies are now dropping everything from children's insurance to mini med plans.

Dr. Howard, when the rubber meets the road and the bottom line that we are looking at is obviously controlling costs and preserving patient choice, what are some suggestions that you have to—that you can make to achieve those goals?

Mr. HOWARD. I would very seriously consider starting over again and devolving more power to states to experiment with health care reforms each in their own way. Massachusetts will go its way. And that is an experiment that is ongoing. In Massachusetts, we have seen costs rise after the health care reforms there, particularly for small businesses. There was a study done by Cogan, Hubbard and Kessler that found that for small businesses, insurance premiums rose by 14 percent over and above what they had been—the rate had been prior to health care reform in that state.

But I think having different states take different approaches and see what works is a better way to go than trying to commit the entire nation to one one-size-fits-all program at the present time. I would also think seriously about frontloading our efforts to control costs and not expanding coverage to large populations until we have established that we have, in fact, controlled costs and can use those savings to expand coverage to people who need it the most.

So I think a cost-first approach that trusted, but verified our attempts to control costs and could pass on those savings to small businesses, to employers and to employees through higher wages would be a better approach than the approach we are taking right now, which is basically we are going to spend about a trillion dollars over the next decade with the hope in the second decade we will recoup substantial savings.

Mr. THOMPSON. Thank you.

Ms. Johnson, thoughts?

Ms. JOHNSON. Pardon?

Mr. THOMPSON. Any thoughts in terms of suggestions to—looking at controlling costs and preserving patient choice?

Ms. JOHNSON. Obviously, my experience is that the costs aren't being contained. I think that, again, perhaps to start over and to try a new bill that really looks at controlling the actual costs of health care, which, in fact, impacts the cost of insurance that employers are making. And I think also if you are looking at the actual to get the bottom line of what it is going to cost the individual insured are, in my case, my teachers are going to have to pay. It is all about the premiums that the cost of the insurance costs.

So unless those premiums are held in check, which is not happening, and they are continuing to go up because of the rising costs

of health care period, as well as the impact of the Affordable Care Act, then we just need to stop, start, restart and try again.

Mr. THOMPSON. All right.

Dr. Van de Water, before I came here, I spent 28 years managing in rural hospitals, always looking at the pending, looming Medicare cuts since 1997, the Balanced Budget Act. And you contend that health care reform will reduce the budget deficit. As you know, the new law relies on over a trillion dollars in tax increases and Medicare reductions.

In your testimony to the Budget Committee last week, you said that the record demonstrates that Congress has repeatedly adopted measures to produce considerable savings in Medicare and has let them take effect. Well, since the new health care law did not reform the scheduled reductions in Medicare physician payments, the so-called doc-fix as we have always known it, do you support the current reduction of 28 percent in Medicare physician payments?

Mr. VAN DE WATER. Certainly, not.

Mr. THOMPSON. So how do we—doesn't that just speak to the—I think, the credibility and the reality of half a trillion cuts that were as a part of the health care act of whether—it speaks to the reality of whether they will really be imposed going forward?

Mr. VAN DE WATER. No, those are two entirely different things. The sustainable growth rate formula existed before the enactment of health reform. It is still in law. Even if health care reform were repealed, the sustainable growth rate cuts would still be scheduled to take effect. They do represent the problem and issue that has to be dealt with. But it is quite distinct, and it is separate from health reform.

Chairman KLINE. The gentleman's time has expired.

Mr. Andrews?

Mr. ANDREWS. Thank you, Mr. Chairman.

Thank the witnesses for their excellent presentations this morning.

Mr. Trautwein, welcome back to the committee. An overwhelming majority of Americans believe that if you have had breast cancer or diabetes, you shouldn't be denied insurance coverage and you shouldn't be charged more for it because of your preexisting condition.

As you know, one of the problems with that change, though, is if you don't have more people in the insurance pool, those changes would, in fact, drive up premiums dramatically for businesses and for individuals. One of the ways that has been discussed to avoid that problem is to have an individual mandate to buy health insurance coverage. Do you favor that?

Mr. TRAUTWEIN. We have backed away from—in our vision for health care reform, we called for consideration of an individual precisely because of that problem. We backed away from that because of the—what we thought were a lack of short-term cost savings, quicker and——

Mr. ANDREWS. Now, I understand that. But let me—because the time is limited. You did say to this subcommittee of this committee about 2 years ago that you would urge consideration of an individual mandate to obtain basic coverage and leverage voluntary employer contributions. So if we are starting with a clean slate,

which we are with the repeal, would you include an individual mandate in the replacement bill?

Mr. TRAUTWEIN. I think the politics have demonstrated that that is a highly controversial element. And——

Mr. ANDREWS. Okay.

Mr. TRAUTWEIN [continuing]. Highly—a much litigated element.

Mr. ANDREWS. Everything is controversial in politics. On the merits—because I am sure you care about the merits—would you include that in the replacement bill?

Mr. TRAUTWEIN. I would not.

Mr. ANDREWS. Okay.

Mr. TRAUTWEIN. I would go about it differently.

Mr. ANDREWS. So you have changed your position from 2 years ago?

Mr. TRAUTWEIN. That context for that was in the—in relation to the NRF platform for forward—and not in the context of——

Mr. ANDREWS. Okay. So you don't favor it now, but you did favor it then?

Mr. TRAUTWEIN. That is correct.

Mr. ANDREWS. Okay. The second thing I wanted to ask you was there are at least two members of your association, Macy's and the Kroger Company, that have taken advantage of the early retiree health care payments. Would you repeal those, or would you keep them?

Mr. TRAUTWEIN. There is not a lot of retiree health care in retail. And certainly, that would be an issue to look at if—in a new bill. Certainly, as it is still part of the current law, that is not something that we have——

Mr. ANDREWS. But again, because the presumption of this hearing is we don't have the new law. It has been repealed. So if we were starting to write on a clean sheet of paper a new health care law, would you or would you not include the subsidies for early retirees for employers?

Mr. TRAUTWEIN. I probably would not include that by reason of the cost of those provisions.

Mr. ANDREWS. Okay. The third question I want to ask you—you testified clearly that you think that an employer mandate is destructive of jobs, particularly in the retail sector. I want to read to you from a letter dated March 19, 2010. I am quoting, "We need to introduce clear standards for shared responsibility that provide stable insurance coverage and prevent cost shifting from the uninsured to those with coverage. We believe that individuals, employers and government must all take responsibility for managing and financing health care."

The letter goes on to say that the signatories urge and expect Congress to take the first essential step and pass meaningful health reform this year. That was the day before the vote on the bill.

One of the signatories was the Wal-Mart Company, to that letter. Do they misunderstand the retail business? Or why are they wrong in taking that position?

Mr. TRAUTWEIN. I don't represent that company. The National Retail Federation does not represent that company. We had a difference of opinion on that particular issue.

Mr. ANDREWS. But on substance, why are they wrong?

Mr. TRAUTWEIN. I think on the substance, based on the breadth of the retail industry and the difficulty we have in managing the cost of labor because we have a lot of people in our industry, it is destructive to that. Now, why they took their position is in their own counsel. And I encourage you to ask them.

Mr. ANDREWS. Well, unfortunately, none of them were invited as witnesses today to talk about why they support the employer mandate. But I am sure that they will come in the future.

Thank you. I yield back the balance of my time.

Chairman KLINE. I thank the gentleman.

Mr. Barletta?

Mr. BARLETTA. Thank you, Chairman Kline.

Dr. Howard, the Patient Protection and Affordable Care Act that we are examining here today contains a massive expansion of the Medicaid program in order to reduce the number of uninsured, leaving states to foot the bill. As someone from a commonwealth that is home to more than 2 million medical assistant recipients, and as someone whose commonwealth is facing serious budget issues, won't these costs place an even greater burden on the states and resulting in an even higher unemployment rate?

Mr. HOWARD. Congressman, I think that is absolutely correct. The states right now face severe budget crises, in no small measure due to Medicaid. Medicaid currently counts for about 20 percent of state budgets, crowding out spending from everything to education to infrastructure.

Although the federal government will be picking up, over time, about 90 percent of the costs of the Medicaid expansion, that still leaves about $21 billion in new costs for states, along with $12 billion in new administrative costs, forcing either other large cutbacks in programs or sharp tax increases. Medicaid is also a deeply flawed program where recipients have worse access to doctors and poorer outcomes for diseases like cancer and heart disease.

There is a very short-term increase in the Affordable Care Act for physician payments under Medicare for 2 years. But then it goes away. I don't know who is going to pick up the spending for that provision. Perhaps it will be the states, another unfunded liability that is placed on their books. So I completely agree that half of all insured Americans under the Affordable Care Act will be pushed into a Medicaid program that is deeply flawed, tremendously expensive and a real burden on state budgets.

Mr. BARLETTA. Thank you.

Ms. Johnson, first I want to thank you for your hard work taking care of our children.

Ms. JOHNSON. thank you.

Mr. BARLETTA. Three years from now, the health care law will force employers with more than 50 employees to provide government-sanctioned coverage to their employees under a penalty of $2,000 per employment—employee tax. Ms. Johnson, our country has experienced an unemployment rate that is at or above 9 percent for 21 consecutive months. How will your company adjust to this new provision? And how will it potentially effect the unemployment of your employees?

Ms. JOHNSON. I think that is the big unknown. I think there is so much unknown about what happens in 2014. I know that, based on what I have been told, that I can expect the increase that I was hit with this year, next year and the next year and the next year, which will position me in a place to say can I pay the costs of the premiums that are already a half a million dollars. Can I pay that rising cost?

Or do I have to say, okay, do I save my bottom line and keep my business flourishing and thriving and say to my employees, go and buy—you have a chance now to buy individual insurance, you have a chance to go the exchanges? But what does that mean? And what will they be able to buy? And what will that mean to my ability to attract the quality teachers that we have?

We have functioned for years and priding ourselves on being the employer of choice in the early education business. So I am in a real conundrum because the costs of the premiums is eating away at my bottom line. But at some point, you have to make a business decision and say, if there is an option for you, this is the option.

It may not be as good an option as you have for health care now as far as out-of-pocket costs. But it is available for you. And we will have to do it that way. I don't know is, I guess, the answer. I just have to weigh the impact of the cost of the premiums and the availability of the exchange.

Mr. BARLETTA. And quickly, Mr. Trautwein, how will the employer mandate effect retailers, especially smaller growing retailers, near the 50 employee threshold?

Mr. TRAUTWEIN. Well, I think it is causing many retailers to consider whether they grow beyond that. Under PPACA, there is a provision where you aggregate part-time employees, which is very important to my industry, and use those to determine whether you hit the 50 full-time equivalent threshold or not. So I think it is going to have an effect, particularly as we get towards 2014, when the mandate is effective, in terms of their hiring practices.

Mr. BARLETTA. And do you believe that the reverse can also happen, where employees—employers around the 51 mark, 52, may actually lay people off to get under the 50 employee threshold?

Mr. TRAUTWEIN. It could very well. I use the example of that employer with 52 full-time employees and very substantial cost implications for that employer.

Mr. BARLETTA. Thank you.

Chairman KLINE. I thank the gentleman.

Mr. Kildee?

Mr. KILDEE. Thank you, Mr. Chairman.

Dr. Van de Water, what effect or effects with the early retiree reinsurance program have on employers in both the short-term and the long-term?

Mr. VAN DE WATER. The early retiree reinsurance program that you ask about is the provision that helps employers that do offer health coverage to early retirees by paying for a portion of the more expensive claims that those employers have. Clearly, doing so will make it much easier for employers to continue offering that type of coverage, which has been eroding in many cases up to now. So that should have a very positive effect.

Mr. KILDEE. Many employers in my district have expressed interest of getting into that program. Again, do you find that they are doing so because they find a benefit in so doing?

Mr. VAN DE WATER. Absolutely. Of course, yes, sir.

Mr. KILDEE. Could you speak of what benefits a business might have?

Mr. VAN DE WATER. Let us say the early retirees, that is people between ages 55 and 65, are often the most expensive insured—or members in employers' insurance pool because unfortunately, as we get older, our health care needs increase. And, of course, some of those early retirees may also be early retirees simply because their health status forced them out of the workplace. So that this reinsurance pool, which helps the employer bear the costs of the more expensive early retirees, can save that employer a substantial amount of money and can make it possible to continue offering health coverage, not just for the early retirees, but for the employer's entire workforce.

Mr. KILDEE. So in this instance, we find something that is liked or beneficial to the employer and also to the early retirees.

Mr. VAN DE WATER. Absolutely. And I would say the small-employer tax credit is another example of that.

Mr. KILDEE. I thank you very much, Doctor.

Chairman KLINE. I thank the gentleman.

Dr. Heck, you are recognized.

Mr. HECK. Thank you, Mr. Chairman.

Thank you to the panel members for being here this morning. As an emergency medicine physician, which provides the ultimate safety net in health care, taking care of everyone, regardless of ability to pay, time of day or chief complaint, I echo the nearly universal sentiment that we need to improve our health care delivery system.

Likewise, as a former small-business owner, I was gravely concerned about the impact of the Affordable Care Act on my business and those of other businesses in Nevada, a state that already suffers from the highest unemployment rates in the nation. Claims of benefits from the small-business tax credit and the increased number of employees covered failed to address what happens when that credit expires and the businesses are caught in a catch-22 of continuing the benefit that they have been provided with a credit or decreasing the size of their workforce.

I also spoke with larger businesses. A medical staffing company, primarily physicians, with 2,800 employees that previously had seen single-digit premium increases over the course of years was hit with a 40 percent increase this year; a food retailer that provides coverage to both full-time and part-time employees within my district is concerned about the 90-day coverage requirement, a timeframe that is shorter than what they currently provide, even though they provide insurance and what that impact is going to have on their ability to continue to provide coverage.

Dr. Van de Water, you stated that the "impact will be primarily be on employees' after-tax compensation," and implied that that impact would be short-term. Hardly a consolation to residents of Nevada, which also suffers from the number one rates in foreclosures and bankruptcies.

Ms. Johnson, a question for you. Dr. Van de Water also stated that the short-term economic impacts will be "quite small." Would you characterize your premium increase of 18 percent as quite small? And could you please tell us about your employees' reaction to the addition of a deductible to their policy?

Ms. JOHNSON. No, in a word, it is not quite small. And it has been a gradual response. I think you—at our open enrollment this month, it was, "Oh, okay." But now as they begin to go and access health coverage and the reality of the, "Oh, okay," becomes apparent, it is like, "Oh, no."

I am in preschool business. And we are at the, as I often say, the bottom of the educational food chain, which means our wages are, too. We are proud to pay in the upper quartile of preschool teacher wages. But that is still not a lot, which means that there is a little less—there is very little leftover dollars for them to use to pay for health care, even if insured.

So this was, I think, something that I wrestled with. And what I really wrestle with is what about next year. Okay, we have added a deductible this year. Based on what I understand, we will have an increase similarly or maybe more next year. What will I have to do then? Will I have to raise their premiums, too, and have a deductible? This is something that doesn't seem like we are cutting costs at all, particularly to the insured.

Mr. HECK. Thank you, Ms. Johnson.

Dr. Van de Water, after hearing that impact of the 18 percent premium increase and the impact on the employees and the deductible and how that is further decreasing their after-tax compensation by having to lay out more for health care, would you still characterize those impacts as quite small?

Mr. VAN DE WATER. Absolutely. If one listened carefully to Ms. Johnson's statement, her insurance broker made it quite clear that the very large preponderance of the increase had nothing to do with the Affordable Care Act. Now, according to the Congressional Budget Office and most independent actuaries, the expectation is that the additional costs of the requirements in the Affordable Care Act will be minimal.

As I listened to Ms. Johnson's statement, it appears that her company offers quite comprehensive coverage and that any additional requirements—any additional costs in order to meet the requirements of the Affordable Care Act, whether it be first dollar preventive coverage, which it sounds like her plan may already have, that these costs are minimal. So again, if one—the 18 percent is not the effect of the Affordable Care Act. And the cost increases that are expected next year, again, that is not attributable to the law. So I don't think that causes me to change what I said one bit.

Mr. HECK. Well, what about the impact on the employees who are now having to shell out additional dollars because of the implementation of a deductible from their already low-end compensation?

Mr. VAN DE WATER. Well, two points about that. First of all, most health economists, including a lot of members on your side of the aisle, have long been advocating larger deductibles to make health care consumers more cost-sensitive. So from an overall cost-

control point of view, actually, I think having modest deductibles for other than preventive services, is actually a good idea.

But putting that aside, the 18 percent cost increase is not the result of the Affordable Care Act. Neither is the deductible which Ms. Johnson felt necessary to add to her plan to offset what otherwise had been a very large premium increase. So we are talking about apples and oranges here.

Mr. HECK. Thank you, Mr. Chair.

Chairman KLINE. The gentleman's time is expired.

Mr. Grijalva?

Mr. GRIJALVA. Thank you, Mr. Chairman.

And let me thank the panel for your comments today. I find it kind of ironic the whole discussion is centered around the fact that health care costs are rising as though that was a new concept in the last—let me start—if I may, Ms. Johnson, you suggested, among—you suggested that if this trend continues that we are talking about, premium increases in particular, that you would have to shift to the penalty because that would not—that would be something that would be—you would have to be required in order to continue to provide the health care to your employees. But I thought the comment that you made about the most important thing is to hold premium increases at check.

One of the mechanisms—and I—to me, this kind of reinforces your comment. The idea that a robust exchange with a robust, strong public option as a competitive offset to premium increases and private insurance would be a good suggestion down the road to save money for you and for your employees. How do you feel about that competitive issue with private insurance?

Ms. JOHNSON. I am all about competition. I think competition is what drives prices down. So that is just a bottom line how I think as a business owner.

I don't think we understand completely about what the exchanges really are going to play out to be.

Mr. GRIJALVA. Okay.

Ms. JOHNSON. And so, that—it is the unknown that adds the complexity to the situation.

Mr. GRIJALVA. But the concept of competition is the bottom line for you?

Ms. JOHNSON. Yes.

Mr. GRIJALVA. Thank you.

Mr. Van de Water, who carries—we are talking about costs. Who carries the costs right now of the 35, 45 million uninsured that are—who carries the effects of those costs right now?

Mr. VAN DE WATER. Well, those costs show up in various ways. The uninsured, as you know, do receive some health care. Dr. Heck referred to the care that is available to people who come to emergency rooms. So the uninsured do get some care, but they don't get as much care as insured people do. So increasing coverage is extremely important.

But the costs of that care is paid for by other people, either by other—by people who are insured through paying higher premiums to offset the costs that are incurred by hospitals for the——

Mr. GRIJALVA. Okay. Somebody pays for that?

Mr. VAN DE WATER. Some of it by taxpayers. We have special payments through Medicare and Medicaid to assist hospitals for that kind of care that they provide.

Mr. GRIJALVA. Okay.

Mr. VAN DE WATER. So that the care is ultimately paid for by others.

Mr. GRIJALVA. Okay. Thank you.

And, Mr. Trautwein? Thank you. The effects we—you talked a lot about hiring—how the health care reform could be a constrictor to hiring. What are the effects—what would be the effects of hiring if there was no reform?

Mr. TRAUTWEIN. I am sorry, sir?

Mr. GRIJALVA. What would be the effect on the hiring picture among the—the people you represent, the small businesses, the retailers, if there was no health care reform act?

Mr. TRAUTWEIN. If there was no health care reform act, those retailers who offer coverage would continue to struggle to offer that. Because of the rising costs, fewer smaller retailers would be able to do that. We still have a lot of uncertainty, as Ms. Johnson said, in terms of what the exchange is going to look like, how effective it will be ultimately. But again, we were strong proponents of reform and for good reason.

Mr. GRIJALVA. Okay. So we have talked a lot about costs. You have. And I would suggest that part of the discussion—and that is what I asked Mr. Van de Water and Ms. Johnson—has to do with benefit as well. And in that analysis, I think, if I may say, you are leaving out a significant portion about what the long-term benefit is of health reform. And that would—has been the goal all along.

With that, I yield back, Mr. Chairman.

Chairman KLINE. I thank the gentleman.

Ms. Roby, you are recognized.

Mr. ROBY. Thank you, Mr. Chairman.

Thank you to each of you who are here today. I want to take a moment, if I might, and just expand on the discussion that Mr. Heck had a few minutes ago. Clearly, our economy needs job growth and expansion of industries and ideas in the workforce and not federal regulations that place such a heavy burden on them.

At the same time, we do need to implement common-sense health care changes that are free market solutions, tax code reform, medical malpractice reform and increase competition across state lines. And I have recently shared some examples as it relates to a Pizza Hut owner in Headland, Alabama that is going to be forced to shut his doors because he can't afford this as well as an owner of pharmacies throughout the Southeast who has the ability to create jobs but is fearful to do so because he doesn't know what the federal government is going to do to him next.

So expanding on the discussion before, Ms. Johnson, your testimony, if I did nothing and just renewed our policy, due to the 18 percent increase, I simply cannot afford to absorb this increase to the bottom line. And then Dr. Van de Water said even if health care reform were to impose some costs on employers, economic principles strongly suggest that the impact on business hiring decisions would be small.

So my question is to you, Dr. Howard, is if you could help reconcile—I mean, clearly, there is two very different, differing opinions from Dr. Van de Water and Ms. Johnson. And I would like to hear your take on the real economic impact on job growth when you hear from small-business owners like the Pizza Hut owner, like the owner of the pharmacies and certainly, the testimony of Ms. Johnson, which seems to be in conflict with Dr. Van de Water's position.

Mr. HOWARD. Well, I think that small businesses are in an environment where they direly need relief from health care costs. The purported exercise of health care reform was to "bend the curve of health care costs." The defense apparently is now costs will go up, but they will be small. But I would like to point out that for small-business owners and mid-size business owners, those new costs are unchosen. They are being forced on them.

They will have to pass those costs along to their employees in the form of lower wages. That may seem to be a minor impact, but I think given the rest of the economy and all the other cost pressures we are facing, I think that that is not the right message to send to employees, that you are going to take the hit now in the hopes that 10 or 15 years down the line, maybe we will see health care costs slow.

And we also have to understand that this is in the context of everything else that we are asking small employers to do, that small employers are trapped in very dysfunctional state insurance markets where they face dozens of state mandates on insurance that drive up the cost of insurance. So their choices are limited.

We are limiting their choices even further. And we are asking them to pay more costs. So I think that that is the central problem here, is we have put more problems on their plate rather than taking them away.

Mr. ROBY. Thank you very much.

Mr. Chairman, I yield back.

Chairman KLINE. I thank the gentlelady.

Mr. Kucinich, you are recognized.

Mr. KUCINICH. Thank you very much, Mr. Chairman, members of the committee. Two of the main concerns I hear from businesses when it comes to health care are predictability and costs. They want predictability because without it, it is hard to make long-term decision and investments.

The Affordable Health Care Act provides some protection from the unpredictability of wild leaps in health care costs for those in small insurance pools. It does that by putting more people in the same risk pool, by providing ways to challenge excessive rate increases and by capping the amount of money insurance companies can spend on things other than your health care. It is not perfect, but it is much more than we had before the bill passed.

I also hear from businesses that they want lower health care costs for their employees. The lower the costs, the easier it is to attract talented workers. It is especially true for small businesses, who are competing against larger businesses for talent. And many businesses want lower costs because they are at huge competitive disadvantage compared to their competition overseas.

The per-person health care costs in the U.S. in 2008 were $7,538; in the U.K., $3,129; in Canada, $4,079; in Holland, $4,063; in Spain, $2,902. In fact, among our OECD competition, no one is even close to us in health inefficiency. And who bears the burden of that? Our businesses.

The Affordable Care Act, again, provides some help there with tax credits and also because it insulates people from the highly expensive individual insurance market by pooling them together. It makes sense. The more people in the pool, the lower everyone's cost because the costs are spread among more people.

Now, Mr. Van de Water, if part of the reason small business would get more predictability is because their employees can band together with others in a bigger risk pool, would their costs be even more predictable if everyone in the U.S. was in a single risk pool, the very definition of a single payer plan?

Mr. VAN DE WATER. Mr. Kucinich, that is a difficult question. I think there is always going to be unpredictability in health insurance markets. But I think that your general—the general thrust of your question is correct, that the—you know, the larger the pool, the less likely premiums are to change by very large amount from one year to the next due to modest changes in the makeup of the risk pool. I think your general idea——

Mr. KUCINICH. Well, let me follow-up on that. Thank you, Mr. Van de Water. If businesses get relief from health care costs under the Affordable Care Act, would they get even more relief from the tremendous burden of inflated per-capita health care costs under a single payer plan?

Mr. VAN DE WATER. Quite possibly.

Mr. KUCINICH. Well, I just wanted to use this opportunity to suggest to my colleagues, who want to dramatically change the Affordable Care Act or perhaps dismantle it, that this—these hearings are also a good opportunity to look forward. Thank you.

I yield back.

Chairman KLINE. I thank the gentleman.

Dr. Roe, you are recognized.

Mr. ROE. Thank the gentleman for yielding.

Thank the panel for being here.

And I will start by looking at my own experience of 30-plus years of small-business owner, like Ms. Johnson. We started out by providing 100 percent of the health care coverage for all the families and people who worked for us. We now have over 300 employees who get insurance in our business, in our practice.

And we are at the process of looking at if we dropped the coverage that we had and paid the penalty, we could save our practice almost a million dollars a year. This is real-world stuff. I haven't been here but 2 years. This is real-world stuff.

And Dr. Van de Water mentioned a moment ago about the impact being minor. Well, let me give you just an example of what health care reform did in the state of Tennessee. We started a reform in 1993 called TennCare. And we had the problem with the health care system in America, as has been pointed out many times and I saw in my patients, that it costs too much money to come to the doctor and to enter the health care system. There is no question about that.

The second problem we have was we had a segment of our population that didn't have affordable coverage, that couldn't afford it. So they are out there. We know who they are. And lastly, which hasn't been mentioned, is that there is a huge liability crisis in America that is adding to the cost of the care.

I just spoke to the CEO of Mount Sinai Hospital Monday. Sixty-million his hospital system pays in liability insurance. In our state, we started with a $2.6 billion program. We have a lot of uncovered people. This is going to compete the hold the health care costs down.

Ten budget years—in just 10 short years, that had gone to $8.5 billion, taken up about 33 or 4 percent of the entire state budget. We have essentially paid for the health care increase in the state of Tennessee by not adding any new dollars to our higher education system in 20 years. We have 50 less highway patrolmen than we had 30 years ago. And we have 2 million more people that live in the state.

So it has not held the costs down. And our Democratic governor, who just was turned out, Governor Bredesen, called this new plan the mother of all entitlements because he as a state CEO or governor, executive, understood that. And how we managed the costs in Tennessee was we rationed care. We basically cut people off, and we limited the number of visits that they have.

Let us look forward, also, at Medicare, which started as a $3 billion program in 1965. The estimates—there wasn't a CBO then. But the government estimates were this would be a $15 billion program in 25 years. Now, the actual number—does anybody know what it was 25 years later? Over a hundred billion dollars. And today it is over $500 billion.

So I don't see anywhere in there that these costs are being held down. And the way you are going to haul costs down in America is personal responsibility and disease management and liability reform. That is how you are going to do that, not through this plan.

And I want to—I am going to stop after making that statement and just—Ms. Johnson, to you, in your own business, you are a real-world businessperson and owner. I have heard this story over and over again. The other thing, before I finish, is the great secret in government programs is they never cover the costs of the care.

In our state, TennCare pays about 60 percent of the costs. And Medicare pays about 90 percent in our state. So guess what happens? That cost is shifted to private insurers. And you not only have the cost of your increase with technology liability, you also are paying for the costs that the government isn't paying for. So what they just did was expanded massively a Medicaid program that is already failing. And it is going to shift more costs.

So you are absolutely right. Your costs are not going to go up 8 or 10 or 12 percent. They are going to go up 20 percent when this happens. And to say that with a straight face that this is going to hold costs down, I don't see any way it can possibly do that.

Mr. MILLER. Would the gentleman yield?

Mr. ROE. No, I want to finish my time.

Ms. Howard (sic), yes, ma'am?

Ms. JOHNSON. To respond to that, I agree wholeheartedly. Just because the particular changes in the Affordable Care Act that im-

pacted my policy this year has 3 to 5 percent does not speak to the whole question because the health care industry and the costs to insurance companies that is impacting my premiums is still reeling out of control.

And it had been my hope that whatever bill, health reform bill, we had would be hauling those costs under control as well. And I don't see that happening. So it is not just the specific 3 to 5 percent that increased directly related to removing the caps on durable medical equipment, et cetera, et cetera. It is also the fact that there are increasing health care costs that this reform bill is not curtailing.

Mr. ROE. Dr. Howard, any comments?

Mr. HOWARD. Well, I think that is a good observation that the costs are shifting substantially. I know that in many states in general, Medicare pays 80 percent of what private insurers pay. And Medicaid pays about 60 percent, I believe. So it is a tremendous cost shift and a tremendous problem for physicians and why more and more physicians are simply refusing to see patients.

Chairman KLINE. The gentleman's time has expired.

Mrs. McCarthy is recognized.

Mrs. MCCARTHY. Thank you, Mr. Chairman. And thank you for having this hearing.

It has been interesting listening to the testimony. And I guess—I spent the majority of my life as a nurse before I got here. And I think one of the things that we have to understand—you know, I have heard statistics going all over the place. They mentioned the 1960s.

As a nurse in the 1960s, I earned $25 a week. My health insurance at that particular time was probably about $1.30, $1.40 because we did pay into our health care, as we do here. You know, everybody keeps thinking that we as federal employees get free health care. We pay into it.

And we also, by the way, in my opinion, for what I pick out—we are talking about the exchange. I picked the insurance company that I wanted. Someone else on my staff, especially the younger ones on my staff, they pick out the insurance that they want. But the difference is we do not have a cap. If I get sick, I will be covered. And that is what we are trying to give to the American people.

Costs have gone up. Health care has gone up to the point of where small businesses, large businesses could no longer sustain it. So something had to be done.

Now, no one is going to say this has been a perfect bill. But it is a start—and hopefully improve upon it as we go forward.

You know, I heard again a number of times on the small businesses, you know, that are exempt from the responsibility requirement of expanding their insurance coverage under the bill from 46 percent of companies offering coverage in 2009 to almost 59 percent of companies offering coverage in the year 2010. I do believe that once people get over this fear of what the health care bill can do and we bring everybody in—because there was mention before—our hospitals are paying for people that don't have insurance.

And if you don't have care, preventative care—this country is basically a very unhealthy country. And they are. And yet, with med-

ical technology, with what—certainly if you have the access to a doctor and they discover you have high cholesterol at the age of 40, you are going to take medication, hopefully, that will prevent a stroke or a heart attack down the road. That is the whole idea of what this bill is.

But the truth of the matter is if we had done nothing, your small business wouldn't be eligible for health care. Your large corporations would not be able to afford health care. And this is the debate that will continue to go on. But to say we should repeal and stop and don't do anything, in my opinion, is the wrong way to go.

So, Mr. Van de Water, I wish that you would talk a little bit more on the cost savings from preventative care. We are already seen some of the estimates from CBO, which is unusual for them. They don't like to do anything that they don't have hard facts on. But also spreading the coverage across the whole country so that people that don't have health care will have health care and how that helps the pool.

And hopefully, Ms. Johnson could be able to have cheaper insurance or at least sustain the costs. I am not going to say she is going to get cheaper insurance. I will say she will sustain the costs so they are not going up high.

Mr. VAN DE WATER. Happy to do that, Mrs. McCarthy. But if I might, I would like to amplify on a point that you made earlier on in your remarks suggesting that there was—I forget the exact term you used, that there are unnecessary concern, fear, anxiety about the effects of the health reform legislation.

As we listened to some of these individual stories, I think we seem to lose sight of the big pictures, which is that, in fact, the vast preponderance of employers already offer health insurance coverage, which is, in fact, substantially more generous than that that would be required by the Affordable Care Act. Ninety-five percent of employers with more than—with 50 to 199 workers—even for firms with between 25 and 49 workers, 92 percent of those firms already offer coverage. And like, with Ms. Johnson's firm, that coverage, in general, is already more generous than would be required to meet the requirements of the Affordable Care Act.

So the additional costs that would be imposed on those firms is truly minimal. And that is not a matter of speculation. You know, that is a matter of fact.

In terms of the cost controls which you asked about, it would be nice if we could start to slow the growth of health care costs substantially right away. But I don't think that any of the supporters of this legislation—or, I hope, of any other—had ever promised that that difficult task could be accomplished right away. We have been faced with year-in, year-out double digit, in my cases, increases in health care costs.

And I want to emphasize that those are not unique to public programs. Those increases have been both in the private insurance—people buy, again, as we have heard from Ms. Johnson and Mr. Trautwein's examples. So what we will need to do is to make major reforms. What most analysts believe is we will need to make major reforms in the health care delivery system to develop ways of delivering care that are more cost-effective. This law begins, but it will take some time to do.

Chairman KLINE. Thank you, sir.

The gentlelady's time has expired.

Mrs. MCCARTHY. Thank you.

Dr. Des Jarlais?

Mr. DESJARLAIS. Thank you, Mr. Chairman.

As I sit and listen to the debate today and hear my colleagues tell us that we should not be afraid to move forward and be afraid of what is in this bill, as a physician, I can tell you that that is not the sensation and the feeling I am getting as I sit here listening.

We look at the federally run programs in our health care system today, which encompass over half of the covered lives in America through the Medicare, Medicaid and veterans system. And I don't think anybody is going to sit here today and give gold stars and A ratings to the success and the state of these programs.

So the thought of moving forward with this Affordable Health Care Act without apprehension causes me great pause as a physician. And I guess I would like to ask Dr. Van de Water—you had mentioned that we have 32 million uncovered lives right now that will be addressed with this act. And there is roughly 330 million people in our country.

It should be noted that before this health care bill was passed, if you study the polls, 75 percent of Americans rated their health care as good or excellent. It is hard to get that many people in this country to agree on anything.

So we have 25 percent that are dissatisfied. And I assume that the 32 million that you speak of are in this group. Can you break down that group of 32 million? Because that was always kind of a moving target during the debate.

Mr. VAN DE WATER. When you say break down, you mean in terms of how these people would achieve coverage?

Mr. DESJARLAIS. Are these people that don't qualify for Medicaid? Are they people that are here legally or illegally? Are they people that are willfully uninsured?

Mr. VAN DE WATER. Thirty-two million figure is the number of additional people who would receive coverage under the Affordable Care Act. And that number is not exactly, but more or less evenly divided between people who would achieve coverage under Medicaid and those who would achieve coverage through the new health insurance exchanges.

Mr. DESJARLAIS. Do you know approximately how many?

Mr. VAN DE WATER. I could look it up and——

Mr. DESJARLAIS. Okay. But somewhere, there is a portion of those that would qualify for an existing plan?

Mr. VAN DE WATER. Some of the Medicaid people would qualify under existing law. But that number I don't have at my fingertips.

Mr. DESJARLAIS. Okay.

Dr. Waters (sic), could you comment on how we can expand coverage to 32 million people and yet reduce costs and preserve quality of care?

Mr. VAN DE WATER. That is exactly what——

Mr. DESJARLAIS. Okay, go ahead.

Mr. VAN DE WATER. Yes, that is exactly—we do that through the Affordable Care Act. That is exactly what the Congressional Budg-

et Office and the Medicare actuary project is what is going to happen. As I said, that in the near-term, as we bring coverage to 32 million more people, of course, there will be a modest increase, which, I believe, at its peak is only about 3 percent of national health spending.

After that, the rate of growth of costs will slow. And in—early in the next decade, if one extrapolates the actuary's projections, the level of spending will be less than it would have been without the Affordable Care Act. And the reason for that—the reasons for that are among the things that I mentioned, the provisions in the law that change reimbursement practices to focus on the value rather than volume, the provisions that eliminate the over-payments for Medicare Advantage plans, the excise tax on high-cost health plans and so forth.

Mr. DESJARLAIS. And you feel this can be done while maintaining quality of care, despite what my colleague from Tennessee spoke of in terms of the failed TennCare plan?

Mr. VAN DE WATER. The gentleman knows more about—being from Tennessee, knows more about the details of TennCare than I do. But our quality of care leaves a lot to be desired. The most studies show that even in our—while many people get excellent care for certain purposes, that is still in—I forget the precise number, but about 40 percent of people who are in the medical care system don't get all of the recommended care that they should.

That was a recent analysis by the Rand Corporation that, I think, appeared in Health Affairs Magazine. So there is a lot of room for improving quality while reducing costs.

Mr. DESJARLAIS. Thank you, Dr. Van de Water.

Dr. Howard, would you comment on whether or not you feel that we can expand coverage while reducing costs and maintaining quality?

Mr. HOWARD. I think it is going to be extraordinarily difficult. I think that a number of the programs that Dr. Van de Water talked about could very well increase quality. But they are likely also to increase costs.

That may be something we should do. But if you are giving people more services or preventative services, costs are going to go up. The thing that CMS scored as having the largest impact on health care spending was going to be the across-the-board provider cuts that are happening in the latter decades of the Affordable Care Act.

And that means that at long-term, Medicaid rates are going to drop below those of Medicaid. And we already know there are serious access problems there. There are going to be serious access problems for seniors if that happens. So that is not likely to happen.

So I think in the short-term, we are going to see costs go up in the hopes that costs will go down at some point. But since we can't predict what the economy is going to look like in 6 months or a year, I think trying to figure out what the health care system is going to be in 15 or 20 years is impossible.

Mr. DESJARLAIS. All right. Thank you.

Chairman KLINE. The gentleman's time has expired.

Mr. Holt?

Mr. HOLT. Thank you, Mr. Chairman.

Before I get to my questions, I just wanted to underscore something that Mr. Miller raised earlier, which is, in fact, there has been a significant increase in small businesses offering health care benefits to their employees in the last year. UnitedHealth Care Group, the nation's largest insurer, added many tens of thousands of new customers, mostly small businesses. I am quoting from that well-known Socialist organ, Forbes Magazine.

Blue Cross/Blue Shield of Kansas City, an astounding 58 percent increase in the number of small businesses purchasing coverage; Coventry Health Care, more than 100,000 new workers, an 8 percent jump. Thirty-eight percent of these Kansas City Blue Cross/Blue Shield businesses had not offered health care benefits before.

Says the writer, "If you are all about beating up on President Obama, you can conveniently forget this bit of data as if it never really happened. However, if your interest is to make health care available to more Americans, this should be a happy day for you, no matter what your ideological beliefs."

Let me turn to some other details here.

Mr. Van de Water, not much has been said this morning about the medical loss ratio. When this committee, particularly Mr. Tierney, pointed out to the country that most insurance companies were spending maybe 75 percent of an employee's health insurance premiums on actually providing health care, they were astonished. And now under the health care law, there is a requirement that the medical loss ratio increase, in some cases, to 85 percent and that there be auditing.

In other words, insurance companies would be required to spend more of the collected premiums on actually providing health care. What effect do you think that will have on the issues that we are discussing today?

Mr. VAN DE WATER. Clearly, Congressman, the provision requiring that insurance companies spend 80 or 85 percent of the premium dollar on health care is going to mean that employees or individuals who buy insurance on their own are going to be getting considerably more insurance value for their dollar. There has been some—was some talk earlier this morning about waivers which HHS has been granted to allow some firms to offer these so-called mini-med policies during the interim between now and 2014 before the exchanges come into effect.

If anyone has ever looked at those policies, the value that is received for those is extremely poor, that in many cases, we read the one offered by McDonald's to some of its employees only about 60 cents of the premium dollar is spent on health care.

Mr. HOLT. Well, thank you. I venture to say that as the auditing proceeds, the public will be astonished once again about how these companies are doing business.

Ms. Johnson, your premiums have gone up, and they are proposed to go up for the subsequent year. Did you bring with you the figures for the past 10 years?

Ms. JOHNSON. No, I did not. But they have been progressively going up.

Mr. HOLT. Is it more or less than the national average of a doubling of policies from 1999 to 2009?

Ms. JOHNSON. I couldn't speak to——

Mr. HOLT. Was it comparable—it was probably a doubling?

Ms. JOHNSON. I couldn't speak to the exact. I wouldn't want to say something that would not be truth.

Mr. HOLT. Well, for most businesses around the country, it was a doubling, which I take as evidence of the need for this health care legislation, not an argument against it. These happened before the health care bill was passed. The premium notices that you are getting in the mail these days are independent, as Mr. Van de Water has said, and so, independent of the health care legislation.

Now, in the few seconds I have remaining, let me ask a very quick question, then, to Mr. Howard. You say that small businesses need relief. I would ask whether a 35 percent tax credit for doing what they want to do and are doing is considered relief.

I would also ask, secondly, whether you believe that having patient-centered primary care, bundled payments, required 85 percent medical loss ratio, payments that record—reward accountable provider groups and assume the responsibility for continuum of patients' care, more emphasis on outcome rather than procedures, independent payment advisory board, new innovative center within CMS for streamlining testing and rapid communication and expansion of successful models, enhanced rate review, price transparency will, in fact, bring down the costs—put downward pressure on the costs of medicine.

Chairman KLINE. Yes, Dr. Howard, if you think you can answer that in, you know, 20 or 30 seconds——

Mr. HOLT. A yes or no.

Chairman KLINE [continuing]. Please do. Otherwise, we will need to move along.

Mr. HOWARD. Out of that laundry list, I think that a lot of things are going to increase costs. The tax credit you referred to——

Mr. HOLT. Will increase costs?

Mr. HOWARD [continuing]. Is going to go—the tax credit you referred to is going to go away. And then employers are going to be left in state insurance exchanges, where there are going to be very expensive plans available to them.

Chairman KLINE. The gentleman's time has expired.

Mrs. Biggert?

Mrs. BIGGERT. Thank you, Mr. Chairman. And thank you for having this hearing. I have to state for the record that I am not a doctor on this side of the aisle. But I am a lawyer, so I want to turn to a little—something a little bit different.

And, Dr. Howard, what has happened to ERISA? You know, this was a really voluntary—so that companies, employers could voluntarily offer health care benefits. And I think there was on the other side of the aisle talking about the states making all these different things. But this—ERISA is kind of what held it all together.

And then I want to go something else. So if you could answer that briefly.

Mr. HOWARD. I think that ERISA has been a tremendous benefit for large firms. It has helped them to design employee benefits they thought best fit their mix of needs and the needs of their employees. Obviously, even large companies are seeing health insurance increases and need to find better ways.

There are some very innovative things happening at companies like Safeway and Whole Foods, where they are working with their employees to find ways to hold down costs through innovative disease management programs. I think that kind of experimentation, giving more ability to companies to experiment with those types of plans, is a very valuable way to go.

Mrs. BIGGERT. But under the—this new law, will they be—will ERISA exist?

Mr. HOWARD. I think that there is going to be a gradual erosion of ERISA, both because of the incentives for individuals to drop out of employer-based coverage because of the larger subsidies that are available on the exchanges, but also because the ability of states under—in the state insurance exchanges to make broad changes to plans that are available in their state markets—of course, ERISA is not affected by that. But I think there is going to be more of a push, particularly on states, to try and get ERISA-based companies into the insurance pool and to alter ERISA to make it possible for them to get at the—the companies' employees into those pools.

Mrs. BIGGERT. Thank you. Then you said that that were, like, 700 waivers already, based on——

Mr. HOWARD. Seven hundred and thirty-three.

Mrs. BIGGERT. What about—I got a company, employer, a restauranteur in my district. He has 100 employees. He is not able right now to offer insurance. So with the new law, he is going to have to put all of his employees on—in the exchanges. And then he is going to have to pay a $2,000 penalty every year for each employee, which is $200,000. He doesn't make that much. So his conclusion was, "Who wants to buy a restaurant?"

And yet, there are all these waivers for large companies and things. Why are the waivers being given when the law was written in such a way that they should have to comply under that, too?

Mr. HOWARD. Well, I would defer to some of my colleagues with experience in the small-business environment. But I would say very briefly that the administration has recognized that there will be a substantial decrease in coverage or a substantial increase in premiums if the waivers had not been given to those companies.

Mrs. BIGGERT. Okay. Then the other issue is the court cases in 26 states having filed to repeal this law or to make certain changes. And it seems like it is two to two now with some states saying they want to keep it and other states saying let us do away with it.

But their latest decision that has come out from, I guess it is, Florida with the district judge saying that, not only is the individual mandate that individuals have to purchase health care unconstitutional, but because there is no separability clause in there, that the whole law should be repealed. And what do you think of that? Or how do you——

Mr. HOWARD. Well, I think that the individual insurance mandate is deeply troubling. You are forcing individuals to buy plans or buy kinds of plans they wouldn't necessarily choose for themselves and are going to face, in many cases, higher costs as a result of it.

In Massachusetts, as I recall, 200,000 people, I think it was, who were exempted from the individual mandate because the costs were

so high. I think a number of people after the mandate goes into effect are going to look at the cost of insurance. They are going to opt not to buy it and sit out. And that is going to raise the risk of adverse selection in those pools and raise the cost of insurance.

So I think it is extremely problematic. And we need to look at better ways of incentivizing people to purchase the kinds of insurance that fit their needs, particularly consumer-driven-types of insurance.

Mrs. BIGGERT. Thank you.

Would anybody else like to comment on that briefly?

Mr. VAN DE WATER. I would just like to point out that the insurance exchanges will offer a range of policies. And, in fact, that the lowest level required has an actuarial value of 60 percent, which is well below the level offered by the typical high-deductible plans with the health saving account. So, in fact, the notion that people are going to be forced to buy one particular kind of insurance that doesn't suit their needs is, I think, fundamentally off-base.

Mrs. BIGGERT. Well, even those that have been—have waivers, it is very strict, the terms of how they can keep that waiver.

Chairman KLINE. The gentlelady's time has expired.

Ms. Hirono?

Ms. HIRONO. Thank you, Mr. Chairman.

There is no question that health care costs have been rising and the premium costs to businesses have been increasing year by year, often by double digits long before we ever passed the Affordable Care Act. And so, just slowing the ever-rising costs of health care, which already represents one-sixth of our gross national product—totally unsustainable, no end in sight. Just to slow that down, never mind bending the curve, I think, is a huge accomplishment for us.

Now, Dr. Howard, you said something that was really interesting in response to the question of what would be your approach to how we could slow the ever-rising costs of health care in our country, unsustainable. You said that we should encourage the states to experiment with health care reform. You mentioned Massachusetts. And as a matter of fact, Hawaii, for over 35 years, has had probably the most progressive and comprehensive health care law in the entire country.

It is an employer-mandated—mandate law, where there is no exception for small businesses. All businesses in Hawaii that have full-time employees must provide health care for which the employee pays only 1.5 percent of their wages. Which means that most of the employers in Hawaii who have full-time employees pay 100 percent of the coverage. There is no discrimination for preexisting conditions. There are no lifetime limits.

And, in fact, the largest health care provider in Hawaii moved very quickly to provide an option for—opportunity, I should say, for the parents of children to put their kids on the policies until 26, before that requirement even kicked in. You know, things did not fall apart as a result of Hawaii's prepaid health care law. And, in fact, Hawaii's people live the longest, partly because we have early access to health care. That means prevention.

So you would think with all of this that when we were discussing health care reform and the Affordable Care Act that I would be

hearing from businesses all across Hawaii to eliminate Hawaii's prepaid health care law. Quite to the contrary. What the businesses in Hawaii were saying is please, please exempt Hawaii's law from whatever you folks are doing because they—our law works.

Now, when you say that states should be given that opportunity, if the states go and follow the direction of Hawaii. So I think that would be great. Do you have any awareness of Hawaii's law, Dr. Howard?

Mr. HOWARD. I am sorry to say that I don't. I mean, I think the central point to make is is that no two states are exactly alike. And so, Massachusetts or Hawaii may have found a set of arrangements that works well for their given populations, their given circumstances. The circumstances aren't the same for California or Texas or Oklahoma, Florida or any other state. Each state has to find its own way.

There may be a mix of state programs that will work. One, I think, very interesting parallel was to welfare reform during the 1990s, where one state, Wisconsin, took the lead, found a workable program for welfare reform that later became a model for the nation and was extraordinarily effective.

So I think there is a tremendous aspect to state experimentation, as it has often been said. Use the states as laboratories of experimentation before we commit the entire United States to one program, however attractive it may seem in Massachusetts or in Hawaii.

Ms. HIRONO. Well, given that, though, I don't think that we should all be reinventing the wheel. We should learn from other states' experiences.

Dr. Van de Water, do you have any awareness or familiarity with Hawaii's prepaid health care law? Would you like to—and if you do, would you like to comment?

Mr. VAN DE WATER. Well, I have some familiarity, Ms. Hirono, with it. Recently I worked—I was the study director for a study panel of the National Academy of Social Insurance, which was examining administrative issues that would be involved in implementing health reform. And, of course, the administration of mandates is one of the things we looked at.

And, of course, the employer mandate in Hawaii, which, as you say, has been in effect for 35 years, is an important example that we looked at. And I think I am personally quite pleased that you brought it up because it does show, as you said, that if a requirement is imposed broadly so that all employers have to meet it, then it should be quite successful.

Clearly, if one particular employer by itself, say, in the retail market might be able to—because of competitive pressures, it might not be able to provide health insurance to its workers. But if it knows all of its competitors are going to have to do the same thing, as is the case in Hawaii, the whole situation is different. And, as you said, as far as I understand, Hawaii still has fast food restaurants. It still has daycare centers. The world——

Ms. HIRONO. Well, the world certainly has not come to an end in Hawaii. And, in fact, I would say that the business community in Hawaii pretty much uniformly want us to be able to continue this kind of a law, which is not to say it is perfect, of course, be-

cause health care costs in Hawaii also go up. But an economist I talked to in Hawaii, who one of his specialties is looking at Hawaii's law, said that premium increases in Hawaii has been lower because—in large part, because of the prepaid health care law.

And I would also say that those states that have actually in place processes that allow for rate review, those states have a better chance for controlling health care costs, especially those that require prior approval. Thank you.

I yield back.

Chairman KLINE. The gentlelady's time has expired.

Dr. Bucshon?

Mr. BUCSHON. Thank you, Mr. Chairman.

And thank you, witnesses.

This is directed at Dr. Van de Water. Would you agree that when CBO scores a bill, they have to go on the assumptions that are in the bill to—and they can't—they don't have much leeway in interpreting what the law says, they just have to score it based on what the assumptions are? Yes or no?

Mr. VAN DE WATER. No.

Mr. BUCSHON. Okay. Then tell me why that would be.

Mr. VAN DE WATER. CBO estimates the effect of the law, evaluates the legislative language of the law. But the sponsor of the legislation does not have the opportunity to specify what economic and technical and other estimating assumptions the CBO uses in estimating what the effects of that legislative language would be.

Mr. BUCSHON. Okay. Then in the case of the Affordable Care Act, would you agree or disagree that some of the cost savings are the projected decrease in Medicare outlay of funds, decreasing reimbursement in the past and that was used as part of the cost savings in the Affordable Care Act?

Mr. VAN DE WATER. Yes, there are reductions in Medicare payments.

Mr. BUCSHON. Okay. And then would you also, I think, said earlier when someone asked the question about Medicare cuts and it is most universally believed that, especially the ones relating to the doc-fix-type of cuts, most likely will never occur. Then would you agree that the CBO's estimate of the repeal bill most likely is incorrect, based on the assumption that the Medicare cuts will occur and that—because from the direction I see it, you can't have it both ways.

Mr. VAN DE WATER. I guess I would make about three points in response to this. First, as I said in response to an earlier question that the sustainable growth rate formula is not an element of health reform as following the preceded health reform and that will continue after——

Mr. BUCSHON. But that is always reversed with the doc-fix, which is part of the assumption of your savings in the Affordable Care Act. Is that correct or incorrect?

Mr. VAN DE WATER. But the second point that I believe has also been referenced is that I and a colleague looked at all of the payment, Medicare payment reductions that were required by Medicare recent legislation over quite a number of years. And we found that with—in almost all cases, with a sustainable growth rate formula being the primary exception, that those payment reductions

were allowed to go into effect. So that if one based—generalizes based on past experience, that one should not necessarily conclude that the payment reductions contained in the Affordable Care Act will not go into effect.

Thirdly, even if Congress decided to change those provisions in the future, those changes would have to be paid for and would not add to the deficit. So that does not—none of that suggests that the CBO's scoring is in any sense incorrect.

Mr. BUCSHON. Well, history will tell us, but past history has told us that the effects of the decreasing reimbursement have always been reversed, historically, and that those savings and assumptions in the Affordable Care Act will ultimately prove not to be true.

Mr. VAN DE WATER. But actually, sir, that is not correct. Even looking at the sustainable growth rate formula by itself, that some of the reductions required by that did go into effect. Moreover, many of the recent changes have been offset and have been paid for and have, therefore, not up to this point, added to the deficit.

Mr. BUCSHON. Okay. Thank you.

Mr. Trautwein, many people believe that there will be a large number of employers that will drop their private health insurance and have their employees go on the exchanges or Medicaid. If a large number of employers, more than the expected number, drop their health insurance coverage, what effect will this have on the cost projections for the Affordable Care Act, going forward?

Mr. TRAUTWEIN. I think it could vastly increase the federal outlays for subsidies in the exchanges that could cause costs to greatly increase. Now, I don't think there is going to be a bottom dropping off in January 1, 2014. But I think you will see—but partly because of the differential item I showed in my oral testimony, between the cost of providing care versus the penalty amounts, you are going to gradually see an increasing movement away from employer-sponsored plans, not all at once. But accumulatively, I think that is going to increase.

Mr. BUCSHON. So over the course of the, say, the next two or three decades, you see that occurring? And then your projection on the overall federal government expense for health care would see a dramatic increase, compared to what the current estimates are?

Mr. TRAUTWEIN. In my opinion, yes.

Mr. BUCSHON. Thank you.

Chairman KLINE. The gentleman's time has expired.

Mr. Tierney?

Mr. TIERNEY. Thank you, Mr. Chairman.

Ms. Johnson, I feel your pain, as a former small-businessperson who represented a lot of small businesses, was a president of a local chamber of commerce. I agree that our private insurance companies were jacking up our premiums over and over again. Every quarter, the price would go up, and it was difficult.

And I think in part we are trying to make the private insurance companies more accountable for it, or at least provide some relief for consumers here. And that is a part of the act on that.

We have had some talk about cost containment. So I want to talk about what most health economists, about 250 that I am knowledgeable about, thought was a bill that had in it almost every cost-containment provision that policy analysts have considered effec-

tive in reducing the growth of medical spending. And that is referring to the ACA, the Affordable Care Act.

So, Mr. Trautwein, I want to ask you. If you had your druthers and we are starting from scratch, would a bill that you were drafting include payment innovations like bundled payments and accountable care organizations that reward providers based on the value of their care, and not just the volume of their procedures?

Mr. TRAUTWEIN. Certainly, many of the——

Mr. TIERNEY. Okay, so you would?

Mr. TRAUTWEIN. I would.

Mr. TIERNEY. Okay. Would a bill that you were drafting put in an excise tax on high-cost insurance plans to make consumers more cost-sensitive and discourage excess utilization?

Mr. TRAUTWEIN. I might not do that.

Mr. TIERNEY. You might not do that? But you might also do it? You are uncertain?

Mr. TRAUTWEIN. It is among the universe of cost reduction strategies that we and others have——

Mr. TIERNEY. Okay. An independent advisory board that would develop and submit proposals to reduce cost growth and improve quality in both Medicare and the health care system as a whole, would you provide for one of those in your bill?

Mr. TRAUTWEIN. Again, these are part of the universe——

Mr. TIERNEY. But would you or would you not? Or you are uncertain?

Mr. TRAUTWEIN [continuing]. That we work with the Finance Committee, Congressman.

Mr. TIERNEY. Okay. A center for Medicare and Medicaid innovation, that is a center that would test, evaluate and foster rapid expansion of new ways to increase the value of care, would you think that would be a good thing to put in your bill?

Mr. TRAUTWEIN. I think it is a positive idea——

Mr. TIERNEY. Measures to inform patients and pay as to what the quality of health care providers, would that be something you would put in your bill?

Mr. TRAUTWEIN. We have supported that as well.

Mr. TIERNEY. Okay. Increased funding for comparative effectiveness research so people would know which procedures work better than others?

Mr. TRAUTWEIN. I am less sure of that.

Mr. TIERNEY. Okay. Promote wellness and prevention, provisions that do that, would you include those in your bill?

Mr. TRAUTWEIN. Not in their present form——

Mr. TIERNEY. Well, but would you have provisions in there for——

Mr. TRAUTWEIN. First dollar coverage for preventative care. But preventative care——

Mr. TIERNEY. But you would put provisions in there with respect to wellness and prevention?

Mr. TRAUTWEIN [continuing]. Itself is very important. I am sorry, sir?

Mr. TIERNEY. You would put provisions in there regarding wellness and prevention?

Mr. TRAUTWEIN. Most——

Mr. TIERNEY. All right. Would you consider an exchange, a group of insurance companies that would participate and compete, that would lower costs with their competition, increase innovation, would that be something you would consider putting in your bill?

Mr. TRAUTWEIN. Their group purchasing has been a common—this committee has worked on association health plans and small-business health plans for a year. How the exchanges under the Affordable Care Act actually are going to work in progress, that is the unknown.

Mr. TIERNEY. Would you provide for some sort of way to increase competition, innovation on that so that companies would compete against each other?

Mr. TRAUTWEIN. I would. I am reluctant on the exchange structure.

Mr. TIERNEY. But you would have something in there that——

Mr. TRAUTWEIN. Certainly. Certainly.

Mr. TIERNEY. Okay. The medical loss ratio provisions, where we finally say to small-business carriers and large-business carriers that no less than 80 or 85 percent of your premium dollar has to be spent on actual health services. They no longer can keep jacking up your CEO salaries, your bonuses, your dividends and all of that and your management costs at the expense of the consumer. And if you don't do it, you get a rebate, which in this case, the health and human services estimates that about $322 rebate per average will come out for people in the individual market, and $164 for people in the small-business market.

So the companies have to tell us what they are spending their money on. It has to be transparent. Consumers will see it. And if they don't meet those marks of 80 to 85 percent of a premium dollar spent on health services, they are getting a rebate. Would that be something you would consider in there?

Mr. TRAUTWEIN. Not in its present form. It has been a very crude instrument. And greater transparency, absolutely.

Mr. TIERNEY. Would you—do you think that insurance companies ought to have at least some benchmark where they spend money on health services as opposed to all the other things I mentioned?

Mr. TRAUTWEIN. I am reluctant——

Mr. TIERNEY. Lobbyists and, you know, bonuses and things of that nature?

Mr. TRAUTWEIN. I am reluctant to see that sort of a government fiat.

Mr. TIERNEY. So you are okay with those things?

Mr. TRAUTWEIN. But generally, transparency is very helpful.

Mr. TIERNEY. Okay. So what is it that—what cost provision aspect that most health care analysts and policy analysts have would you put in that you don't find already in the bill?

Mr. TRAUTWEIN. For one thing, as has been mentioned, medical liability reform would be helpful. I would also——

Mr. TIERNEY. So would that two-tenths of a percent of the costs of health care in the world here, in the country?

Mr. TRAUTWEIN. A lot of—under the Affordable Care Act, a lot of the cost controls are directed through Medicare as its role as a market leader, which will help bring that. I would have brought

those earlier to the private market and tried to more quickly reduce the cost of medical care in order to bring costs down.

Mr. TIERNEY. So you would have the federal government impose these on private companies?

Mr. TRAUTWEIN. Not impose those, but make those more widely available and encourage those.

Mr. TIERNEY. Well, so, you just want to wish they would do it as opposed to require it?

Chairman KLINE. The gentleman's time has expired.

Dr. Foxx?

Mrs. FOXX. Thank you very much, Mr. Chairman. I would like to yield my time to Dr. Roe.

Mr. ROE. I thank the gentlelady for yielding.

I would like to pose a question. Does anyone on the panel think that seeing a doctor is part of health care? A show of hands. You think seeing your physician has anything to do with health care?

Mr. TRAUTWEIN. Yes.

Mr. ROE. Well, thank you. Because that is what the sustainable growth rate does. If we don't pay our physicians—I just talked to a medical oncologist in downtown Manhattan yesterday who is barely able to keep his practice open because of the reimbursement he is getting from Medicare. So what did we do with this plan? And we do need health care reform. Let me make that very clear. I am all for that and have many ideas about it, none of which were listened to during the debate. But I have many ideas.

We are taking $500 billion out of an already under-funded Medicare plan, and we are adding 3 million people per year to that plan. And the boomers start this year. So I can promise you, going over time, when you have got more people chasing fewer dollars, you are going—and you are paying your doctors less, your providers less, you are going to decrease access, increase costs and decrease quality. I can promise you that is absolutely what will happen.

We are seeing in Tennessee right now we are having a very difficult time getting our Medicare patients seen and almost impossible in some specialties to get our TennCare, or Medicaid, patients seen, which we have just expanded. If we had taken the $500 billion and shored up the Medicare system, certainly with SGR—and a lot of people don't know what that is. It is a formula about how doctors are reimbursed. Also in the Medicare plan, we are going to reduce payments to hospitals, to outpatient care, to hospice care and so on.

The other question, Mr. Trautwein, I want to ask you—if this plan, if this health care plan is so great, why did 700 plus companies opt out of it?

Mr. TRAUTWEIN. I think in terms of the—in terms of HHS and the waivers, this has to do with a corner of the Affordable Care Act, which in two aspects impinged upon limited benefit plans, both the restrictions on annual benefit limits as well as the medical loss ratio standards. Had the law been devised better, you might not have had that problem of taking coverage off the table for 1.4 million American lives.

But, you know, I would not have written the law that direction. But the steps that the administration has taken to deal with this coverage, both in terms of insurers who issue this coverage on a

fully-insured basis in the market, which is where most of the minimed coverage comes in the market, there are some companies who self-fund that coverage. And that is where some of this amount goes. But they really backed themselves into a corner and have created a process, though generally not suspect, it creates an appearance of a problem.

Mr. ROE. I think the other thing that we noticed in Tennessee was is that half the people that got on TennCare had private health insurance coverage and dropped it when the public plan came out there. And we also noticed when we cut off—when the governor had to, because of cost constraints, half the people went back on their private health insurance. So they dropped it, which is exactly what is going to happen in this exchange. I have already seen that occur already in our state.

I think one of the things that disturbs me about this is when government decides what I as an individual need as health insurance, what—and I can't make that decision for myself, my family or my business. The government decides that. I think you have just empowered—I don't think it was intentionally done.

But I think you empower the very people you didn't want to, which are the lobbyists, because they are going to come to me and say, "Look, I have got the greatest knee replacement," or, "I have got the greatest procedure," or whatever. It may not help me as a consumer, but I have got to pay the extra costs, either as a business or as an individual.

And one of the things you could do to make health insurance much cheaper—one of the years for me was letting me as an individual deduct my premium, just like a business does. That would have been very simple. You could have lowered my costs by 35 percent by doing that.

Dr. Howard?

Mr. HOWARD. Well, I think that medical malpractice reform is also tremendously important because it changes how doctors practice. Their perception that they have to provide tests or services or even hospitalization that they don't think are medically necessary out of the fear of getting sued is an enormous problem that even outweighs the direct cost of the medical malpractice premiums that you face.

And I would also take issue with the idea that the SGR is something that could be left out of health care reform. It is the most critical—as you put it, the most critical aspect of health care is getting to see a doctor. So putting, you know, doctors outside of the health care reform and then saying, "We are going to fix this later," I think, is the wrong approach.

Mr. ROE. Thank you.

Chairman KLINE. The gentleman's time—gentlelady's time has expired.

Mr. Payne?

Mr. PAYNE. Thank you very much.

Ms. Johnson, you are the one where the rubber meets the road. I understand you are a very successful entrepreneur with your daycare business and doing very well. And although my colleagues have asked you some questions, I was not in the room. So I would just like to once again—because I think you are probably the most

important person at the table, in deference to the men here, all due respect.

In your testimony, you state that a renewal of your 2010 policy would have resulted in about an 18 percent premium increase. And you attribute this, of course, to the new mandate and administrative costs associated with the new health care provisions taking effect this year. Now, however, it is my understanding that the costs for individual and employee—employer premiums have skyrocketed in the past decades, which underscores the need for the Affordable Health Care Act, in my opinion.

Now, a Kaiser Family Foundation study found that between 1999 and 2009, the premiums for health care more than doubled. And I have a son who is in local government. And he says that the cost of health care with your employees and city participants is just going through the roof. So the costs of health care seem to continue to go up.

On the other hand, preliminary studies of the impact of the affordable health care have already reported a growth of health care coverage among small businesses, including those not mandated under the new law as a result of the cost-saving provisions. Now, I know my ranking member from New Jersey, Mr. Holt, asked the question, they tell me. But it seems that the findings match reports from insurers who share that the number of small businesses purchasing coverage has increased nearly 60 percent in some areas.

Insurers and the Department of Health and Human Services report that the new provisions have only contributed to 1 to 2 percent of the premium increases this year with expected reductions over time. Now, although these provisions make health insurance coverage more affordable and will level the playing field for companies such as your company, Rainbow Station, who currently provide health care—and I really commend you for that, because, as we know, all companies of your nature do not—and have historically subsidized the un-offsetted care for those who do.

So just take into account these reports and the fact that health care reform was not the leading cause of your 18 percent increase, but rather, the way we see it, will curb and reduce the premiums over the next 3 years. If that could be proven to you, would you have a different attitude towards this health care reform bill?

Ms. JOHNSON. I guess we are talking about several things here. The increase in access that you referenced a 6 percent increase, there are some small businesses that have increased access to care, probably the very small businesses that were impacted with the tax credit that has been referenced several times. I am not eligible for that. I have more than 50 employees. In order to access the tax credit, you have to have less than 50 employees and an income limit of $25,000. I don't get that. I am not eligible.

So I think that, in effect, worked. And I am saying that I don't think we need to throw the baby out with the bathwater. And there are some things that worked. And as we go forward and maybe take it off the table and pick what worked and what didn't work, then that is a good thing.

The other thing that we are talking about is cost. And it would assume, from the business owner on the street, that this Affordable Care Act would impact the costs of health care. My rates went up

for two reasons, once because of just the rising costs of health care, but also because of this—the impact of this Affordable Care Act and provisions that I had to add to my policy that I had not had prior.

So I think there is so many things that are here that we are talking about. I don't think that this Affordable Care Act really has addressed, as we have had in many conversations, the actual cost of health care, which will continue to cause my premiums to rise, much like they have over the last years since I have been in business.

I think that the Affordable Care Act has increased some access. But I do think that businesses like mine, which are the mid-sized small businesses, the ones that are really providing jobs on the street, that are growing and adding jobs, we are the ones that are hit by the costs of this increasing, albeit whatever nature it is, 1 to 2 percent for me. It was 3 to 5 percent directly related to the Affordable Care Act—that it is on the backs of mid-sized businesses.

And it seems to me if we are the job creators, if we are the ones that are going to provide jobs and help us pull out of this economic slump that we have been in, then burdening us with more operating costs to the—that will take money from our bottom line and give us less money to grow our businesses, less money to provide jobs, then something is wrong. So I don't know how to fix it. I am just telling you that it is a problem.

Chairman KLINE. The gentleman's time has expired. Thank you.

Ms. Woolsey?

Ms. WOOLSEY. Thank you, Mr. Chairman.

And thank you to the panel. We have heard a lot of things. We have heard about reeling premium costs. We have heard about reeling health care costs. We have heard let us start over. The Patient Protection Affordable Care Act was—it put in place in order to address these reeling costs. And it was supposed to be a start, not a finish. And there is a lot we could do, including the—a robust public option that would save more money, that would provide the competition we need in the exchanges and bring down costs all the way around.

But instead, I hear a lot of you talking about let us get rid of it, and a lot of my colleagues on the other side of the aisle. I want to ask you who do you and where do you think the impetus would have come to stop this—these reeling costs of benefits and health care premiums and health care costs. Was it going to start at the state level? Was it going to start in the insurance—the private insurance industry?

Were the employers going to insist that it happen? When and where was this going to begin, if it didn't start here, now with a program that—and a policy and a plan that was actually flexible enough that we could improve it?

Dr. Van de Water?

Mr. VAN DE WATER. Ms. Woolsey, I think you make an excellent point, that the things that have to be done to slow the rate of health care costs are things that are not always—are not in many cases going to be simple or easy. They are things like imposing an excise tax on high-cost health insurance plans.

They are things like reducing over-payments to Medicare Advantage plan. Had we not done those—taken those steps at the same time as we were also bringing coverage to an additional 32 million people, I think there is a strong reason to believe that those steps never would have been taken at all.

Ms. WOOLSEY. Thank you. Let us go down to the head of the line here, Doctor.

Mr. HOWARD. Thank you, Congressman. I think I would make a couple of different points, one of which is that——

Ms. WOOLSEY. No, where would it have started? That is my point. That is my point.

Mr. HOWARD. All of the above, and bipartisan. I think I would have started with bringing everyone to the table and having a real bipartisan effort to create health care reform because the history shows that successful social policies have to have a lot of bipartisan support, which this did not have.

I think I would have——

Ms. WOOLSEY. Well, why didn't that happen under the Bushes, then, when the Republicans had the White House?

Mr. HOWARD. You are referring to things like the Medicare Modernization Act in 2003 or in——

Ms. WOOLSEY. I am referring to the Patient Protection Affordable Care Act.

Mr. HOWARD. Or in 2007 when President Bush proposed creating a uniform tax credit for health insurance that was——

Ms. WOOLSEY. It did not bring down the costs in premiums and health care costs? No. So where would it have started to get where we need to go so that you wouldn't think it was reeling out of control?

Mr. HOWARD. There were a number of initiatives that the Bush administration did undertake at—pardon me—HHS and other places to increase transparency in the marketplace, offer health savings accounts to Americans, which have been tremendously popular. I think that we should have started with a much more bipartisan process at the beginning of this current administration.

Ms. WOOLSEY. Okay. Then you just said you want it to be partisan because what you just proposed is the most partisan thing that we could—that could have been on the table, savings accounts. Do you mind if we move on to Ms. Johnson?

Ms. JOHNSON. I would say, had we started—we are having a debate, and there is lots of things on the table that we are discussing. But have we really made progress to where we want to go? I would question that.

I think that there has been something on the table for me. And this is my experience. When I became a franchisor and franchised my business, I was really excited, naively, to think that as I grew my business, I could lower my health care costs because my pool would be larger by adding schools across the country. Sadly, that was not the case because insurance cannot be transported across the state lines.

And I think that, which has been on the table for some time, would be a really positive step to add the competitiveness to the marketplace, allow me to insure my entire franchise and lower my

premiums. So that is something that has been on the table. And maybe that is a start that is really has not crossed the finish line.

Ms. WOOLSEY. Thank you.

Neil Trautwein?

Mr. TRAUTWEIN. We have seen a lot of efforts in the private sector, Civil Business Group on Health, for one example. Peter Lee from PBGH is now in the administration and is giving us some hope that we are going to be able to make some progress on it. Employers have been a force for reducing the cost of care, particularly from a preventative health care standpoint and a lot of the growth in looking at, not only self-professed health risks, but also getting into actual monitoring and targeting populations. So I think—in answer to your question, I think the private sector is overlooked as a source for reducing the cost of medical care.

Chairman KLINE. The gentlelady's time has expired.

Mr. Hinojosa?

Mr. HINOJOSA. Thank you, Chairman Kline. I would ask unanimous consent that the statement that I have—a four-page opening statement on health care reform's impact on the economy be made a part of the record.

Chairman KLINE. Without objection.

[The statement of Mr. Hinojosa follows:]

Prepared Statement of Hon. Rubén Hinojosa, a Representative in Congress From the State of Texas

Chairman Kline and Ranking Member Miller, thank you for convening today's hearing on Health Care Reform and its impact on our workforce, employers and economy.

As it stands, some of health care reform's most critical pieces have not been implemented. However, the pieces of the law that have gone into effect have proved critically important for my constituents. Children that are 26 and under can stay on their parent's health insurance policy.

Seniors are receiving rebates as they enter the donut hole and struggle to afford to their costly medications on a fixed-income.

Small businesses that offer health insurance to their employees are taking advantage of tax credits that make health insurance affordable and provide employers a competitive edge.

Over a million young adults are now on their parent's health plan. In my district there are 66,000 young adults that can now stay on their parent's plan as they transition from school to their careers.

About 11,000 small businesses in my district qualify for tax credits to help them pay for the cost of covering their employees

In the short time these credits have been available there has been a 13% increase in small employers offering coverage. Now 59% of small businesses are able to provide coverage to their employees

The CBO has estimated that that health reform will lower the cost of a given plan in the small employer market by 1 to 4 % in 2016.

The American health care system, its attendant inefficiencies, and the debilitating effect it had on American competiveness required this Congress to act in the 111th Session by enacting law that would expand the risk pool, contain costs, especially for small businesses, and make coverage more affordable.

I believe as the law is rolled out, as the administration works with businesses to help them understand their obligations and benefits, and as we in Congress improve on components of this bill, our economy will continue to strengthen, aided by the major provisions of the Affordable Care Act.

Mr. HINOJOSA. I would like to go right into the questions and ask Dr. Van de Water—in your testimony, you state that health reform will increase labor market flexibility because the Affordable Care Act could reduce job lock. Many of my constituents in the 15th

Congressional District that I represent in Texas have asked for more affordable health insurance and for more economic certainty in situations where they lose their employer-based health insurance. Please expand on how the Affordable Care Act will reduce job lock and whether it will result in a more robust economy.

Mr. VAN DE WATER. Certainly, Congressman. I think there are two simple examples or major cases to cite. First of all, for someone who is—looking at someone who is currently working for an employer that does offer health insurance, now if he wanted to take another job that doesn't offer health insurance, that person, he or she, will be able to obtain health insurance as an individual through the new health insurance exchanges with guaranteed issue that the person won't be able to be turned down because of his or her health condition.

And the person will also pay rates that are not higher, depending upon his health status. So that will enable a person to change jobs.

Similarly, if a person would—for example, someone age 63 who might have liked to retire from the workforce, but isn't yet eligible for Medicare. That person might be able to stop working or to cut back his or her hours and, again, take a job that didn't offer insurance and obtain it through the health insurance exchange. So it would give a person a lot more flexibility.

Another key example is a person who want to go off and set up his or her own business as a self-employed individual. That person could also now get a health insurance when under current arrangements, it might be unavailable and unaffordable.

Mr. HINOJOSA. I would like to now ask Mr. Neil Trautwein. The National Retail Federation recognizes that increasing access to health insurance will spread risks and reduce costs. Part of NRF's vision for health care reform recommends that Congress consider requiring individuals to obtain insurance, but not to require the employers. The Affordable Care Act implemented both employer and individual responsibility provisions that built upon our existing employer-based health insurance system in attempts to fairly balance responsibility among the individuals and the employers.

Given that the employer mandate exempts small businesses and, according to CBO, applies to only—to 4 percent of employers nationwide, those with 50 or more full-time employees—question: Do you still propose to exempt all businesses and increase the burden even more on the individuals?

Mr. TRAUTWEIN. The National Retail Federation does not support at present an individual mandate. We encouraged consideration of one to deal with the problem of risk selection at that time. We also proposed building from the existing base of employer-based coverage, not by mandating it, but by making it easier for employers to continue to provide this.

The problem with the particular architecture of the Affordable Care Act is that there are substantial incentives to pay the lesser penalty amount rather than pay for coverage and face the possibility of additional penalties for providing coverage that exceeds an income threshold for some workers, the family income threshold. And also, there is a provision in there for folks slightly above that level that will let them exit the employer plan and take the employer contribution with them, the so-called free choice voucher.

So I think, in our view, the architecture of the Affordable Care Act is flawed, and it may undercut the employer-based system in a much more substantial way after 2014 than would be wise under this—would have otherwise been wise.

Chairman KLINE. Thank you. The gentleman's time has expired.

I want to thank—in fact, we have reached the end of the hearing. I want to thank the witnesses for their great testimony and for their forthright answers to the questions and for your patience as we are shifting back and forth.

Mr. Miller and I were just talking about one of the outgrowths, one of the consequences, if you will, of the new plan to protect committee time so we didn't have to get up and walk away for votes, is every committee is having hearings at the same time. So I thank you very much for your patience.

I now recognize Mr. Miller for any comments he would like to make.

Mr. MILLER. I thank the gentleman. Again, Mr. Chairman, thank you for having this hearing. I think this is a good airing of a lot of the subjects and concerns that have been raised.

And I want to thank the witnesses for participating and the members. I would like to introduce into the record a paper from the Main Street Alliance and also from the Small Business Majority. Both of these items have been given to the majority prior to my request.

Chairman KLINE. Absolutely. Without objection.

[Additional submissions of Mr. Miller follow:]

Prepared Statement of J. Kelly Conklin and David Borris, on Behalf of the Main Street Alliance

CHAIRMAN KLINE AND MEMBERS OF THE COMMITTEE: We appreciate this opportunity to provide written testimony on behalf of the business owners in the Main Street Alliance network for the February 9 hearing on the health care law's impact on the economy, employers, and the workforce.

The Main Street Alliance is a national network of small businesses dedicated to ensuring that small business owners have the opportunity to speak for ourselves on issues that impact our businesses, our employees, and our local economies. In 2009, we both had the opportunity to testify before congressional committees on the topic of health care, sharing our personal stories and speaking about the urgency of reforming health care to make it work for small businesses.

The February 9 hearing was called to explore the impact of the new health care law on the economy, employers, and the workforce. From our perspective as small business owners, this impact is clear and positive: from the new small business tax credits to new protections like rate review and a value for premiums requirement, the health law is already throwing a lifeline to small businesses and creating opportunities for businesses to offer health coverage, save money on premiums, and plow those savings back into business investment and job creation.

While some may raise concerns about the employer responsibility requirement for businesses with more than 50 workers, the fact remains that over 95 percent of our nation's businesses have less than 50 workers (and so would not be subject to this requirement), and 95 percent of businesses with more than 50 workers already offer health coverage. Indeed, this provision only reinforces what the vast majority of larger employers already do, and ensures that responsible employers who offer good-paying jobs with health benefits aren't undercut by competitors who shun these responsibilities.

A much bigger issue—indeed, a true threat to small businesses and our ability to create jobs—is runaway health insurance costs. For example, in early 2010 (before the health care law was passed), one of us received a letter from our insurer offering to renew our current coverage at an increase of 124 percent. The escalation of health insurance rate increases is simply not sustainable for small businesses. Thankfully, the health care law includes a series of provisions that will begin to rein

in these increases and cut costs for small businesses like ours. These provisions include:

Small Employer Health Premium Tax Credits

Business owners in our network from Portland, Maine to Portland, Oregon are already benefiting from the new tax credits effective for tax year 2010. Jim Houser, owner of Hawthorne Auto Clinic in Portland, Oregon with 15 employees, expects to receive a credit of between $5,000 and $10,000 on his health insurance bill. That's serious savings for a small business. Jim has described the tax credit as a "time machine," turning the clock back on his insurance rates.

Premium Rate Review

After years of enduring double-digit rate increases with no recourse, small businesses like ours are encouraged that our states have new tools and new resources to review insurance rates and require insurers to provide justification for unreasonable rate increases. This is one of the most direct ways to protect small businesses and help us do our part to create jobs and grow the economy. There is a high level of market concentration in the health insurance industry and true competition—competition based on consumer value rather than competition based on cherry-picking risk pools—is largely absent. That is why we need robust rate review—to ensure that we're getting a fair shake.

Medical Loss Ratio Requirements

As small business people, we understand that the most important thing about a business is the value you provide to your customers. Yet the insurance industry has lost sight of that. The new minimum medical loss ratio requirements will restore a focus on providing us with value for our premium dollars. And if insurers fail to meet this basic standard, insurance customers like us will receive cash rebates starting next year—potentially to the tune of hundreds of millions of dollars.

State Insurance Exchanges

The state insurance exchanges due to come online in 2014 will level the playing field for small businesses. By creating a mechanism whereby we can band together and shop for coverage in one large pool, the exchanges will give us bargaining power, risk pooling, and greater choice.

The repeal of the health law or the undermining of its core provisions would cause serious harm to small businesses (see attached fact sheet). Certainly, there are improvements that can and must be made to the law. For example, the 1099 reporting provisions and the paperwork burden they would create demand immediate attention. We were heartened that a majority of House members voted to fix this problem last summer (HR 5982, 7/30/2010), and we are confident that the current Congress will get this problem fixed with appropriate speed. We are also confident these types of improvements can be made without undermining the core cost containment provisions and other protections contained in the Affordable Care Act.

The year 2010 saw a dramatic uptick in the percentage of small businesses offering health coverage: among businesses with 3-199 employees, the offer rate increased by 9 percentage points; among those with 3-9 employees, the offer rate increased 13 points, from 46 percent to 59 percent. This is a promising trend, and we need to keep forging ahead, not return to the flawed health care system of the past.

With proper implementation of the health care law, we can truly level the playing field for small businesses like ours. The law promises to benefit small businesses and the American economy by stabilizing our health insurance costs and allowing us to focus on what we do best: creating jobs and providing important goods and services to communities across America.

Thank you,

J. KELLY CONKLIN, *Owner,*
Foley-Waite Associates, Inc., Bloomfield, NJ.

DAVID BORRIS, *Owner,*
Hel's Kitchen Catering, Northbrook, IL.

Bad for the Bottom Line: How Rolling Back the Affordable Care Act Would Harm Small Businesses

Small Businesses are Moving Forward on Health Care

The percentage of small businesses offering health coverage to their employees rose significantly in 2010. For businesses with 3-199 employees, the health insurance offer rate increased 9 percentage points. This increase was driven by an even

greater spike among the smallest businesses: the offer rate among businesses with 3-9 workers rose 13 percentage points, from 46 percent to 59 percent.[1]

Repeal of the Affordable Care Act Would Harm America's Small Businesses

Attempts to cast repeal of the Affordable Care Act (ACA) as "good for small businesses" obscure what repeal would actually do. Here are the facts:

Repeal would raise taxes for small businesses that qualify for the new premium tax credits.

• Starting for tax year 2010, small businesses may be eligible for health premium tax credits valued at $38 billion over a ten year period.[2] As many as 4 million businesses may qualify for a credit, and about 1.2 million businesses could qualify for the maximum credit of 35 percent of their insurance contributions (increasing to 50 percent in 2014).[3]

• Up to 16.6 million people are employees of small businesses that will be eligible for the credit between 2010-2013.[4]

Repeal would leave small businesses vulnerable to continuing price gouging by insurers.

• The ACA gives states new tools and resources to require insurers to justify their rate increases.

• Without robust rate review, insurers will continue to raise rates at their whim. The most recent example: Blue Shield of California, which recently announced combined rate hikes of up to 59 percent, and then thumbed its nose at the state's insurance commissioner when he attempted to delay the hikes.[5]

Repeal would eliminate the guarantee of a basic standard of value for premium dollars.

• Under the ACA, if insurers fail to meet new minimum medical loss ratios (MLR), they'll owe a rebate to customers.

• Projections for the small group market give a mid range estimate of $226 million in rebates, or about $312 per person receiving a rebate, for 2011. Individual market estimates add another $521 million.[6]

Repeal would gut consumer protections for small business owners, employees, and their families.

• The ACA puts in place important consumer protections: for example, a ban on pre-existing condition exclusions, new limits on insurance caps, and the ability to keep children covered up to age 26. These protections directly benefit health insurance customers in the small group and individual markets where small businesses get coverage.

Repeal would renege on the promise of choice, bargaining power, and risk pooling in insurance exchanges.

• Starting in 2014, small businesses with up to 50 employees (100 in some states) and self-employed people will be able to band together to shop for coverage in state insurance exchanges, gaining bargaining power and leveling the playing field with insurers. An estimated 29 million people will get coverage through the exchanges by 2019 (5 million in small businesses that buy in as a group, and 24 million more buying in on their own).[7]

Repeal would be bad for our national bottom line.

• The Congressional Budget Office estimated the repeal bill would add $230 billion to the federal deficit over 10 years, and much more over the following decade.

The final word on health care repeal: It's bad business for small business.

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[1] Kaiser Family Foundation and Health Research & Educational Trust, "Employer Health Benefits: 2010 Annual Survey," September 2010, p. 38, *http://ehbs.kff.org/pdf/2010/8085.pdf*.

[2] Congressional Budget Office letter to Senate Majority Leader Harry Reid, December 19, 2009, p. 6, *http://www.cbo.gov/ftpdocs/108xx/doc10868/12-19-Reid—Letter—Managers—Correction—Noted.pdf*.

[3] Families USA and Small Business Majority, "A Helping Hand for Small Businesses: Small Business Tax Credits," July 2010, pp. 3-4, *http://www.familiesusa.org/assets/pdfs/health-reform/Helping-Small-Businesses.pdf*.

[4] S. R. Collins, K. Davis, J. L. Nicholson, and K. Stremikis, "Realizing Health Reform's Potential: Small Businesses and the Affordable Care Act of 2010," The Commonwealth Fund, September 2010, p. 7 [hereinafter Collins].

[5] Bobby Caina Calvan, "Blue Shield stands by California health care premium hikes," Sacramento Bee, January 15, 2011, *http://www.sacbee.com/2011/01/15/3325248/blue-shield-stands-by-california.html*.

[6] Federal Register / Vol. 75, No. 230 / Wednesday, December 1, 2010 / Rules and Regulations, pp. 74907-74908, *http://edocket.access.gpo.gov/2010/pdf/2010-29596.pdf*.

[7] Congressional Budget Office letter to House Speaker Nancy Pelosi, March 20, 2010, p. 9, *http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf*.

Prepared Statement of John Arensmeyer, Founder & CEO, Small Business Majority

This testimony is submitted in support of the small business perspective on the Patient Protection and Affordable Care Act and its impact on America's 28 million small businesses and the economy as a whole.

Small Business Majority is a nonprofit, nonpartisan small business advocacy organization founded and run by small business owners and focused on solving the biggest problems facing small businesses today. We represent the 28 million Americans who are self-employed or own businesses of up to 100 employees. Our organization uses scientific opinion and economic research to understand and represent the interests of small businesses.

We are testifying in support of the Affordable Care Act, which will help reduce the cost of insurance and medical care while making coverage affordable, fair and accessible. Our research shows that reforming our broken healthcare system has been and still is one of small business owners' top concerns, and that the majority of small employers believe reform is needed to fix the U.S. economy. It also shows that small businesses support key provisions in the law, specifically ones that help them better afford insurance, such as tax credits and insurance exchanges, and those that contain costs. Controlling skyrocketing costs is essential to ensuring small businesses' ability to obtain high-quality, affordable healthcare for themselves, their families and their employees. Our research also shows that absent reform, these costs would continue to escalate, undermining small businesses' success and our economic recovery. The new law goes a long way toward fixing our broken system and stemming these spiraling costs, while helping to create jobs and stimulate the economy.

Our research, which is discussed in more detail below, shows the impact this legislation will have on small businesses and reveals that small businesses support many provisions in the law, especially those that benefit them immediately, such as the small business tax credits. In July 2010, Small Business Majority partnered with Families USA to determine the number of small businesses eligible for a tax credit on their 2010 tax returns, one of the key provisions of the Affordable Care Act.

- We found that more than 4 million small businesses would be eligible to receive a tax credit for the purchase of employee health insurance in 2010.[1]

We also recently commissioned a national survey of 619 small business owners to determine their views on the tax credits and insurance exchanges, another crucial provision of the Affordable Care Act for small businesses. The survey, which was released on Jan. 4, 2011, found that:

- Both the tax credits and the exchanges, once they take effect, make small business owners more likely to provide healthcare coverage to their employees;
- One-third of employers who don't offer insurance said they would be more likely to do so because of both the small business tax credits and the insurance exchanges;
- 31% of respondents who currently offer insurance said the tax credits and the exchanges will make them more likely to continue providing coverage.[2]

However, the poll also found that the vast majority of small business owners don't know the tax credits or exchanges exist to help them afford coverage.

As Congress considers measures to repeal the Affordable Care Act, it's important to understand the consequences this would have on small businesses and our fragile economy.

- Repealing the law would mean small businesses would lose $4 billion per year in healthcare tax credits and many small business protections, including a ban on denying coverage for preexisting conditions. This provision will provide much-needed help to many Americans, including the legions of self-employed individuals—many who currently can't get coverage because of this reason;
- Repeal would rob small businesses of their ability to pool their buying power through state insurance exchanges, and the various cost controls the ACA puts in place would also be lost;
- Repeal would mean an end to the tough enforcement measures in the law, which are saving billions in Medicare waste, fraud and abuse. This would result in higher taxes for employers and employees to fund Medicare, and higher taxes mean fewer jobs.

These are just some of the disastrous consequences repeal of the Affordable Care Act would have on small businesses—consequences that are too severe on our nation's primary job creators. Small businesses create 70% of new jobs in our country. Spending less on health insurance will help them generate larger profits, which will help speed our journey down the road to economic recovery.

My testimony highlights the issues of greatest importance to small businesses in the Affordable Care Act. It explains what we have learned from our scientific research about both the opinions of small employers and the economic impact of reform on small businesses, including the consequences repealing the Act would have on them and the economy overall. The key issues are:

- Why healthcare costs are killing small businesses and sapping our economic vitality;
- How the ACA is already helping small businesses afford insurance and provide their employees with coverage;
- Small businesses' No. 1 priority: Controlling the skyrocketing cost of health insurance and how the ACA tackles this problem;
- What the price of repeal is for small businesses and the economy;
- Why sharing the responsibility will strengthen our small businesses, their employees and the economy.

Healthcare Costs are Killing Small Business and Sapping Our Economic Vitality

National surveys of small business owners consistently show that the cost of health insurance is their biggest overall problem. In fact, the crushing costs of healthcare outranked fuel and energy costs and the weak economy for 78% of small business people polled by the Robert Wood Johnson Foundation in 2008.[3]

Small businesses are at a disadvantage in the marketplace largely because our small numbers make rates higher. According to research supported by the Commonwealth Fund, on average we pay 18% more than big businesses for coverage.[4] Small businesses, including the self-employed, need a level playing field to succeed and continue as the job generators for the U.S. economy.

We hear stories every day from small business owners who can't get coverage because they've been sick in the past or the health plans they are offered are outrageously priced. Louise Hardaway, a would-be entrepreneur in the pharmaceutical products industry in Nashville, had to give up on starting her own business after just a few months because she couldn't get decent coverage—one company quoted her a $13,000 monthly premium.

Many other businesses maintain coverage for employees, but the cost is taking a bigger and bigger chunk out of their operating budgets. It's common to hear about double-digit premium increases each year, eating into profits and sometimes forcing staff reductions. Small business owner Walt Rowen, owner of Susquehanna Glass Co. in Columbia, PA, was quoted a 160% premium increase from his carrier last year, forcing him to find a new plan. These rising bills frequently force business owners to hack away at the insurance benefit to the point where it's little more than catastrophic coverage. That leaves employees with huge out-of-pocket expenses or a share of the premium they can't afford, forcing them to drop coverage. That concerns Larry Pierson, owner of a mail-order bakery in Santa Cruz, California, who says "the tremendous downside to being uninsured can be instant poverty and bankruptcy, and that's not something my employees deserve."

Small business owners want to offer health coverage, and our surveys show that most of them feel they have a responsibility to do so. Small Business Majority conducted surveys of small business owners in 17 states between December 2008 and August 2009.[5] Our key findings included:

- An average of 67% of respondents said reforming healthcare was urgently needed to fix the U.S. economy;
- An average of 86% of small business owners who don't offer health coverage to their employees said they can't afford to provide it, and an average of 72% of those who do offer it said they are struggling to afford it.

It should be noted that respondents to these surveys included an average of 15% more Republicans (39%) than Democrats (24%), while 27% identified as independent.

The exorbitant cost of insurance means that many small businesses are forced to drop coverage altogether. According to the Kaiser Family Foundation, 54% of businesses with fewer than 10 employees don't offer insurance.[6]

This makes small business employees a significant portion of the uninsured population. Of the 45 million Americans without health insurance in 2007, nearly 23 million were small business owners, employees or their dependents, according to Employee Benefit Research Institute estimates.[7] And nearly one-third of the uninsured—13 million people—are employees of firms with less than 100 workers.[8]

With staffs of 5, 10 or even 20 people, small businesses are tight-knit organizations. Owners know their employees well and depend on each employee for their businesses' success. They don't want to see their valuable employees wiped out financially by a health problem, or ignore illnesses because they can't afford to go to the doctor.

The Affordable Care Act addresses all these issues and more. Without reform, we will impede our overall economic growth. Small businesses with fewer than 100 employees employ 42% of American workers.[9] Traditionally, small businesses lead the way out of recessions. Continuing to address the healthcare crisis by implementing the Affordable Care Act is essential to our vitality as a nation. A repeal of this landmark legislation would send our primary job creators back into in a broken system that threatens their competitiveness, discourages entrepreneurism and jeopardizes our economic recovery.

The Affordable Care Act Is Already Helping Small Businesses Afford Insurance and Provide Their Employees with Coverage

Our research shows that small business owners are more likely to provide insurance to their employees because of the tax credits and exchanges provided through the new healthcare law. As I mentioned in my introduction, our most recent research includes a national survey of 619 small business owners that was conducted from November 17-22, 2010.[10] We wanted to gauge how entrepreneurs view two critical components of the Affordable Care Act: the small business tax credits—a provision allowing businesses with fewer than 25 employees that have average annual wages under $50,000 to get a tax credit of up to 35% of their health insurance costs beginning in tax year 2010—and health insurance exchanges—online marketplaces where small businesses and individuals can band together to purchase insurance starting in 2014. The survey's key findings include:

- One-third (33%) of employers who don't offer health insurance said they would be more likely to do so because of the small business tax credits;
- 31% of respondents—including 40% of businesses with 3-9 employees—who currently offer insurance said the tax credits will make them more likely to continue providing insurance;
- One-third (33%) of respondents who currently do not offer insurance said the exchange would make them more likely to do so;
- The same is true for those who already offer insurance, with 31% responding that the exchange would make them more likely to do so;
- However, most respondents are not familiar with the exchange or the tax credits; only 31% of respondents are familiar with the exchange and 43% are familiar with the tax credits.

We believe that once the public, and small business owners in particular, become more familiar with the new law, they will understand the financial benefits and cost savings it provides. In fact, a Kaiser Family Foundation study conducted in January 2010 found that although the public was divided overall about reform, they became more supportive when told about key provisions. After hearing that tax credits would be available to help small businesses provide coverage to employees, 73% said it made them more supportive, and 63% felt that way after learning that people could no longer be denied coverage because of preexisting conditions.[11]

The huge number of small businesses eligible for a credit on their 2010 tax returns shows how wide-ranging the benefits of the ACA are: Small Business Majority and Families USA's study on the number of small businesses eligible for a tax credit on their 2010 tax returns shows that more than 4 million small businesses are eligible.[12] That equates to 83.7% of all small businesses in the country. Perhaps even more encouraging is that more than 90% of small businesses in 11 states are eligible to receive the tax credits, with nearly 1.2 million small businesses nationally eligible to receive the maximum credit.

A recent RAND Health study also examined the impact of the Affordable Care Act on health insurance coverage for workers at small companies. It found that once the new law takes full effect, the percentage of employers that offer insurance will increase from 57% to 80% for firms with fewer than 50 employees, and from 90% to 98% for firms with 51 to 100 employees.[13] Additionally, a study released Jan. 24, 2011 by the Urban Institute (funded by the Robert Wood Johnson Foundation) also shows the positive benefits of the ACA on America's employers. The study debunks claims that the ACA would erode employer-sponsored coverage by providing incentives for employers to stop offering coverage, or that businesses would face increased costs as a result of reform. To the contrary, the study found that overall employer-sponsored coverage under the ACA would not differ significantly from what coverage would be without reform, but that in fact employer-sponsored insurance premiums will fall noticeably, by nearly 8%, and total spending on healthcare by small businesses will also decrease by nearly 9% because of healthcare exchanges and other provisions of the new law.[14]

Analysis after analysis shows that the new healthcare law holds significant promise toward empowering small businesses to provide their employees with health insurance, and to be able to do so without breaking the bank. Instead of repealing

the small business health care tax credit, Congress should be examining how to expand it in order to provide more support to small business.

Small Businesses' No. 1 Priority: Controlling the Skyrocketing Cost of Health Insurance, and How the Affordable Care Act Tackles this Problem

Small business owners are deeply concerned about the exponentially rising cost of health insurance. As Harvard University economics professor David M. Cutler notes, while family health insurance premiums have increased 80% in the past decade after adjusting for inflation, median income has fallen by 5%.[15] When people have less disposable income to spend at local small businesses, small business owners feel the squeeze.

We know from our opinion surveys that small business owners want reform to lower these skyrocketing costs and believe it will be good for the economy overall.[16] The Affordable Care Act includes many provisions to contain costs. These measures will be felt throughout the entire healthcare system, lowering premium costs to small business owners and consumers alike. The Congressional Budget Office estimates the new law will lower federal deficits by more than $143 billion over the next 10 years, and by more than $1 trillion in the following decade. While there is still more that can be done to contain costs within the system, the new law is a great start. It moves our healthcare system toward greater financial stability and provides improved access to affordable, quality care for small business owners and their employees.

Along with small business tax credits and insurance exchanges, the ACA controls costs by reining in administrative costs for small businesses. As previously noted, small businesses pay 18% more on average than large businesses for comparable health policies. This is largely due to high administrative costs, which can be up to 30% of premiums. The law includes administrative simplification programs, helping to put the country on a path to lower-cost, standardized administrative transactions, processes and forms. Additionally, it establishes insurer efficiency standards that require 80% of premium dollars be spent on care, not administrative overhead and executive compensation, for small group and individual plans. For large groups plans, the standard will be 85%. All of these measures will lower the time doctors have to spend on paperwork.

The ACA also includes numerous reforms in Medicare that will reward value of care, not the volume of care. It requires the Department of Health and Human Services (HHS) to adopt value-based purchasing and payment methods for Medicare reimbursements for both physicians and hospitals, and move away from the fee-for-service system that is so costly and inefficient. What's more, cost containment measures made to Medicare will have a ripple effect to other areas of the system, further reducing costs. Harvard professor David Cutler points out the steps the Affordable Care Act takes to cut these costs:

- Payment innovations including greater reimbursement for preventive care services and patient-centered primary care; bundled payments for hospital, physician, and other services provided for a single episode of care; shared savings approaches or capitation payments that reward accountable provider groups that assume responsibility for the continuum of a patient's care; and pay-for-performance incentives for Medicare providers;
- An Independent Payment Advisory Board with the authority to make recommendations that reduce cost growth and improve quality in both the Medicare program and the health system as a whole;
- A new Innovation Center within the Centers for Medicare and Medicaid Services, or CMS, charged with streamlining the testing of demonstration and pilot projects in Medicare and rapidly expanding successful models across the program;
- Profiling medical care providers on the basis of cost and quality and making that data available to consumers and insurance plans, and providing relatively low-quality, high-cost providers with financial incentives to improve their care;
- Increased funding for comparative effectiveness research;
- Increased emphasis on wellness and prevention.[17]

Rather than focusing on repeal, lawmakers should focus on improving healthcare reform, especially when it comes to cost containment. While the new law is a good start toward fixing our system and strengthening our economy, we should be bolstering it even more by including additional cost containment provisions. This will bring health inflation down and help businesses create more jobs.

The Price of Repeal for Small Businesses and the Economy

The shock of repeal would reverberate throughout the U.S. economy. The nonpartisan Congressional Budget Office (CBO) projects repeal would add $230 billion over the next 10 years to the federal budget deficit, and more than $1 trillion in

the decade to follow. The national debt is already at its limit, and expanding the deficit would only cause additional lack of confidence in our nation's ability to recover from the recession.

When you examine what repeal would mean financially for America's 28 million small businesses, the picture is even bleaker. In June 2009, Small Business Majority commissioned noted economist and Massachusetts Institute of Technology professor Jonathan Gruber to apply his healthcare economics microsimulation model to the small business sector. He focused on businesses with 100 or fewer employees.[18] Our research showed that without reform:

• Small businesses would pay nearly $2.4 trillion over the next 10 years in healthcare costs for their workers;

• A staggering 178,000 small business jobs, $834 billion in small business wages, and $52.1 in profits would be lost due to these healthcare costs;

• Nearly 1.6 million small business workers would continue to suffer from "job lock," where they are locked in their jobs because they can't find a job with comparable benefits. This represents nearly one in 16 people currently insured by their employers.

In a recent article he wrote for the Center for American Progress, Gruber again addressed the issue of job lock.[19] He noted that "such a system significantly distorts our labor markets by forcing individuals to stay in jobs that offer health insurance rather than to move to newer and more productive positions where coverage is not available. Millions of U.S. workers are not moving to better jobs or starting new businesses because there is nowhere to turn for insurance coverage should they leave their jobs."

The Affordable Care Act remedies this problem and levels the playing field to support entrepreneurs willing to take a risk and start a new enterprise. Insurance reforms provided in the new law protect these entrepreneurs, and the insurance exchanges established by the law allow the self-employed and small businesses to pool together for lower premium rates.

The Center for American Progress has also weighed in on what small businesses would lose if the Affordable Care Act were repealed. The percentage of small businesses offering coverage has decreased from 68% in 2000 to 59% in 2007; repeal would ensure that this downward spiral would continue. Since 40% of small employers spend more than 10% of their payroll on healthcare costs, repeal would cause those already providing insurance to do so at the expense of increased wages. This would result in less profits, business investment and job creation. Additionally, repeal would mean small businesses would continue to pay on average 18% more for health insurance than large firms. And they won't get the financial relief tax credits and insurance exchanges will provide.[20]

Healthcare reform will also reduce the "hidden tax" associated with health insurance. Repeal would keep this tax in place. The uninsured often delay treating their health problems until they become severe, and public and charity programs pick up a share. However, a portion remains unpaid. To cover the cost of this uncompensated care, health providers charge higher rates when the insured receive care, and these increases get shifted to consumers and small businesses in the form of higher premiums. This creates a "hidden health tax" that inflates the cost of premiums.[21]

Instead of helping us move forward, a repeal of the healthcare law would send us back to the status quo and ensure that small businesses will be unable to play their historical role as the country's primary job creators. In fact, Harvard professor David Cutler projects repeal would destroy 250,000 to 400,000 jobs annually over the next decade, increase medical spending by $125 billion by the end of this decade and add nearly $2,000 annually to family insurance premiums.[22] His summary of what repeal would do to the country is as dismal as it is succinct: "It would hurt family incomes, jobs, and economic growth."

Sharing the Responsibility: Strengthening Our Small Businesses, Their Employees and the Economy

The Affordable Care Act requires that all residents purchase insurance—a requirement that, while not uniformly popular, is necessary in order for reform to be successful. It will ensure a broad distribution of health risks in the market and help bring down costs. While this requirement has spawned contentious debates, we found that many small businesses are willing to help share the responsibility of providing insurance if it means lower costs overall and better quality insurance. Opinion polling we conducted shows that:

• Small businesses are willing to share the responsibility for making health insurance affordable along with insurers, healthcare providers, individuals and government, according to an average of 66% of respondents. By state, those agreeing with the concept of shared responsibility ranged from 59% to 72%.[23]

We've also found that because so many small businesses are bombarded with misinformation, it has made it increasingly difficult for them to determine what the law actually requires of them. Most small business owners are surprised to learn that they won't be required to provide insurance. Businesses with fewer than 50 employees, which accounts for 96% of small businesses,[24] are exempt from all requirements in the law. Businesses with 51 employees or more will be required to provide insurance, however 96.5% of these businesses already cover their workers.[25]

The provision that all Americans purchase insurance was included in the law because businesses and the American people made it clear that they wanted to continue an employer-based health insurance system, not a government healthcare system, such as Medicare for all or Canadian-style healthcare insurance. Because 96% of employers with 51 or more employees are providing health insurance as well as paying federal taxes, it would not be fair to let 4% of employers have a free ride at the expense of the 96% of employers currently offering insurance, and at the same time have their employees covered by taxpayer funds to provide health insurance. Additionally, without the free-rider provision large employers would have an incentive to stop providing health insurance and let taxpayers provide coverage for their employees.

Small businesses today offer health benefits to attract and retain good employees and to be competitive with large businesses. This will continue under reform, except that now these small businesses will have the benefit of buying health insurance through the state insurance exchange—creating market leverage like that of big companies, while driving down and stabilizing costs for their employees.

Conclusion

Healthcare reform is not an ideological issue; it's an economic one. Small business owners know this, which is why they overwhelmingly support reforming our broken system and containing the skyrocketing cost of insurance.

Without healthcare reform, small businesses will once again be mired in a system that drains their coffers and stunts their growth—disabling them from playing their vitally important role as the nation's jobs creators. Harvard professor David Cutler is right when he concludes that repeal is "bad economic policy. The effort to repeal health reform will make our current problems worse."[26] We hope Congress will spend its time focusing on ways to make implementation of the Affordable Care Act as smooth as possible, and instead of trying to dismantle it, fix the parts that need improvement. Our small businesses and our economic recovery depend on it.

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January 26, 2011.

Hon. JOHN KLINE, *Chairman;* Hon. GEORGE MILLER, *Ranking Member,*
U.S. House of Representatives, Education and the Workforce Committee, Washington, DC 20515.

DEAR CHAIRMAN KLINE AND REPRESENTATIVE MILLER: Congress this week is holding hearings on the economic impact of health care reform. We write to convey our strong conclusion that leaving in place the Patient Protection and Affordable Care Act of 2010 will significantly strengthen our nation's economy over the long haul and promote more rapid economic recovery in the immediate years ahead. Repealing the Affordable Care Act would cause needless economic harm and would set back efforts to create a more disciplined and more effective health care system.

Our conclusion is based on two economic principles. First, high medical spending harms our nation's workers, new job creation, and overall economic growth. Many studies demonstrate that employers respond to rising health insurance costs by reducing wages, hiring fewer workers, or some combination of the two. Lack of universal coverage impairs job mobility as well because many workers pass up opportunities for self-employment or positions working for small firms because they fear losing their health insurance or facing higher premiums.

Second, the Affordable Care Act contains essentially every cost-containment provision policy analysts have considered effective in reducing the rate of medical spending. These provisions include:

- Payment innovations such as greater reimbursement for patient-centered primary care; bundled payments for hospital care, physician care, and other medical services provided for a single episode of care; shared savings approaches or capitation payments that reward accountable provider groups that assume responsibility for the continuum of a patient's care; and pay-for-performance incentives for Medicare providers.
- An Independent Payment Advisory Board with authority to make recommendations to reduce cost growth and improve quality within both Medicare and the health system as a whole
- A new Innovation Center within the Centers for Medicare and Medicaid Services charged with streamlining the testing of demonstration and pilot projects in Medicare and rapidly expanding successful models across the program
- Measures to inform patients and payers about the quality of medical care providers, which provide relatively low-quality, high-cost providers financial incentives to improve their care
- Increased funding for comparative effectiveness research
- Increased emphasis on wellness and prevention

Taken together, these provisions are likely to reduce employer spending on health insurance. Estimates suggest spending reductions ranging from tens of billions of dollars to hundreds of billions of dollars. Because repealing our nation's new health reform law would eliminate the above provisions, it would increase business spending on health insurance, and hence reduce employment.

One study concludes that repealing the Affordable Care Act would produce job reductions of 250,000 to 400,000 annually over the next decade. Worker mobility would be impaired as well, as people remain locked into less productive jobs just to get health insurance.

The budgetary impact of repeal also would be severe. The Congressional Budget Office concludes that repealing the Affordable Care Act would increase the cumulative federal deficit by $230 billion over the next decade, and would further increase the deficit in later years. Other studies suggest that the budgetary impact of repeal is even greater. State and local governments would face even more serious fiscal challenges if the Affordable Care Act were repealed, as they would lose substantial resources provided under the new law while facing the burdens of caring for 32 million more uninsured people. Repeal, in short, would thus make a difficult budget situation even worse.

Rather than undermining health reform, Congress needs to make the Affordable Care Act as successful as it can be. This would be as good for our economy as it would be for the health of our citizens.

Sincerely,

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Laura Tyson, S.K. and Angela Chan Chair in Global Management, Haas School of Business, University of California, Berkeley
Robert Otto Valdez, Robert Wood Johnson Foundation Professor, Family & Community Medicine and Economics, University of New Mexico
Paul N. Van de Water, Senior Fellow, Center on Budget and Policy Priorities
Courtney Harold Van Houtven, Associate Professor, Duke University
Lane Vanderslice, Editor, Hunger Notes, *worldhunger.org*
Elizabeth Richardson Vigdor, Research Scholar, Duke University
Anca Voicu, Assistant Professor of Economics, Rollins College
Mark E. Votruba, Associate Professor of Economics and Medicine, Case Western Reserve University

Geetha Waehrer, Research Scientist, Pacific Institute for Research and Evaluation
Jane Waldfogel, Professor of Social Work and Public Affairs, Columbia University
Kenneth E. Warner, Avedis Donebedian Distinguished University Professor of Public Health, University of Michigan
David Warner, Wilbur Cohen Professor of Public Affairs, LBJ School of Public Affairs, University of Texas at Austin
Mark Weisbrot, Co-Director Center for Economic and Policy Research
Thomas E. Weisskopf, Professor Emeritus of Economics, University of Michigan
Charles K. Wilber, Emeritus Professor of Economics, University of Notre Dame
Michael Wilson, Instructor, Harvard Medical School
Cecilia Ann Winters, Associate Professor of Economics, Manhattanville College
Jon D. Wisman, Professor of Economics, American University
Barbara Wolfe, Professor, Economics and Political Science, University of Wisconsin-Madison
Justin Wolfers, Associate Professor of Business and Public Policy, The Wharton School, University of Pennsylvania
Robert S. Woodward, Professor of Health Economics, University of New Hampshire
Vivian Wu, Assistant Professor, University of Southern California
David Zalewski, Professor of Finance, Providence College
Joshua Graff Zivin, Associate Professor of Economics, University of California, San Diego

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Chairman KLINE. And again, I just want to thank all the witnesses for their participation, everybody in the audience, I suppose, for joining us today. We are adjourned.

[Additional submissions of Chairman Kline follow:]

February 7, 2011

The Honorable Kathleen Sebelius
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Secretary Sebelius;

Many of us believe the Patient Protection and Affordable Care Act (PPACA) should be repealed by Congress if the courts do not strike it down first. But, with no assurance of either outcome, we face the decision of whether to participate in the bill by operating state exchanges, or to let the federal government take on that task, if the bill remains in effect in 2014.

In addition to its constitutional infringements, we believe the system proposed by the PPACA is seriously flawed, favors dependency over personal responsibility, and will ultimately destroy the private insurance market. Because of this, we do not wish to be the federal government's agents in this policy in its present form.

We wish states had been given more opportunity to provide input when the PPACA was being drafted. We believe in its current form the law will force our health care system down a path sure to lead to higher costs and the disruption or discontinuation of millions of Americans' insurance plans. Though we still have grave concerns with other provisions of the PPACA, we suggest the following improvements:

- Provide states with complete flexibility on operating the exchange, most importantly the freedom to decide which licensed insurers are permitted to offer their products

- Waive the bill's costly mandates and grant states the authority to choose benefit rules that meet the specific needs of their citizens.

- Waive the provisions that discriminate against consumer-driven health plans, such as health savings accounts (HSA's)

- Provide blanket discretion to individual states if they chose to move non-disabled Medicaid beneficiaries into the exchanges for their insurance coverage without the need of further HHS approval.

- Deliver a comprehensive plan for verifying incomes and subsidy amounts for exchange participants that is not an unfunded mandate but rather fully funded by the federal government and is certified as workable by an independent auditor.

- Commission a new and objective assessment of how many people will end up in the exchanges and on Medicaid in every state as a result of the legislation (including those "offloaded" by employers), and at what potential cost to state governments. The study must be conducted by a neutral third-party research organization agreed to by the states represented in this letter.

We hope the Administration will accommodate our states' individual circumstances and needs, as we believe the PPACA in its current form threatens to destroy our budgets and perpetuate and magnify the most costly aspects of our health care system. While we hope for your endorsement, if you do not agree, we will move forward with our own efforts regardless and HHS should begin making plans to run exchanges under its own auspices.

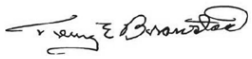
Sincerely,

Governor Robert J. Bentley
Alabama

Governor Nathan Deal
Georgia

Governor C.L. "Butch" Otter
Idaho

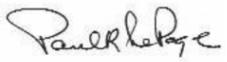
Governor Mitch Daniels
Indiana



Governor Terry E. Branstad
Iowa

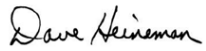
Governor Sam Brownback
Kansas

Governor Bobby Jindal
Louisiana



Governor Paul R. LePage
Maine

Governor Haley Barbour
Mississippi

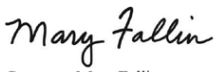


Governor David Heineman
Nebraska

Governor Brian Sandoval
Nevada

Governor Susana Martinez
New Mexico

Governor John R. Kasich
Ohio



Governor Mary Fallin
Oklahoma

Governor-elect Tom Corbett
Pennsylvania

Governor Nikki Haley
South Carolina

Governor Dennis Daugaard
South Dakota

Governor Bill Haslam
Tennessee

Governor Rick Perry
Texas

Governor Gary R. Herbert
Utah

Governor Scott Walker
Wisconsin

[From the *National Review,* August 5, 2010]

Bay State Health-Care Blues

By PAUL HOWARD

The costly Massachusetts experiment has strangled small businesses. Now it is going national.

It's no secret that the template for President Obama's health-reform legislation was the Massachusetts health-care plan enacted in 2006. And it's likely that many of the problems now cropping up in the Bay State will reappear at the national level when key provisions of Obamacare go into effect over the next several years. While the legal fights over Obamacare are grabbing the headlines—on Tuesday, Missouri voters resoundingly rejected the individual mandate—voter approval will ultimately swing on the economy, where the new law will be a lead weight, particularly for small businesses.

When it comes to health-care costs, small businesses are the canary in the coal mine. Lacking the bargaining power to demand lower rates from insurers, small businesses face higher health-insurance costs—and thus are much less likely to offer their employees coverage to begin with. They are also much more likely to drop coverage when costs rise.

In Massachusetts, small-business owners "are giving up out of frustration," an insurance broker recently told the Boston Globe. More and more small businesses "simply can't afford health insurance any more." Prices are certainly going up in Massachusetts's small-group insurance market. The Retailers Association of Massachusetts reports that insurance premiums have risen by about 15 percent annually over the last five years.

Earlier this year, insurance companies asked for large rate increases (up to 32 percent) in the small-group and individual-insurance markets (which were merged into one market as part of the 2006 reforms). The state's response has been to strike back at the insurers: On April 1, in an unprecedented move, the Massachusetts Department of Insurance denied 235 of 274 increases requested by insurers.

Bashing insurers may make for good politics, but it's bad policy. In a leaked email, Robert G. Dynan, the official charged with keeping insurers solvent, wrote that caps (set at 2009 rates) "have no actuarial support" and could lead to "a train wreck" for the state's insurers. Dynan may have a point: The four largest state insurers posted first-quarter losses of over $150 million, which they attributed to rate restrictions imposed on premiums.

Defenders argue that Massachusetts was a high-cost state before the 2006 health-care reforms took effect (which is true), and that those reforms have made insurance more affordable for low-income individuals even if they haven't kept a lid on overall costs.

The reforms, however, may also have shifted costs to small businesses. A July study by health economists John Cogan, Glenn Hubbard, and Daniel Kessler suggests that state reforms may have increased premium trends for employer-provided health insurance, particularly for individual coverage and for small businesses. The authors found that "health reform in Massachusetts increased single coverage employer-sponsored insurance premiums by about 6 percent in aggregate and by about 7 percent for firms with fewer than 50 employees. * * * For small employers, the differential Massachusetts/US growth in small group [family] premiums from 2006-2008, over and above the growth from 2004-2006, was 14.4 percent."

What implications does this have for national health-care reforms and the economy?

For starters, Obamacare makes Massachusetts's expensive, heavily regulated insurance market the model for the rest of the country. New regulations on insurers—including no caps on annual or lifetime coverage and a requirement to cover "children" until they are 26—will drive up costs for small businesses.

Obamacare is also worse than its Massachusetts precursor in several respects. At least Massachusetts was able to finance its insurance expansion largely from existing revenue sources (in fact, about half of the initial funding came from the federal government). Congressional Democrats, however, don't have a rich uncle they can borrow from. So Obamacare includes large new taxes on prescription drugs, health insurance, and medical devices. All of these costs will be passed on to businesses and their employees in the form of higher premiums.

Obamacare also imposes penalties on any firm with more than 50 employees that doesn't offer coverage and has at least one employee receiving a premium tax credit to purchase coverage from one of the state health-insurance exchanges starting in 2014. The fines would be levied as a set fee per employee (excluding the first 30 employees). A new study from the American Action Forum, by former Congressional Budget Office director Douglas Holtz-Eakin and policy analyst Michael Ramlet, explains the implications for job creation:

Hiring one more worker to raise employment to 51 will trigger a penalty of $2,000 per worker multiplied by the [number of workers above 30]. In this case the fine would be $42,000 [21 workers multiplied by $2,000]. How many [firms] will choose not to expand?

Firms with more than 50 employees—those with, say, 55—could also decide to lay off workers or outsource jobs to avoid the penalty.

To be fair, Holtz-Eakin and Ramlet note that the health-care law does include a tax credit for firms that offer employee coverage—but the credit can only be claimed by very small firms (those employing fewer than 25 workers) with average wages below $50,000. Proprietors and their family members are excluded from claiming the credit, even though many small firms are family-run. The value of the credit also gradually phases out as businesses expand beyond ten employees, or as average wages approach $50,000. Given these limitations, the National Federation of Independent Businesses estimates that only 35 percent of firms with fewer than 25 employees will be able to qualify for the credit.

The Bay State's frustration is likely to spread nationwide in coming years, as Obamacare drives costs up and more small businesses drop coverage and slow down hiring to avoid potential penalties. One small business owner (an IHOP franchisee in New Jersey) anticipates that Obamacare's penalties for his 140 workers (up to $220,000) will force him to raise prices or possibly lay workers off. "We are still figuring out how to deal with this," he told the Cleveland Plain Dealer in July. "Ultimately, either businesses will close or consumers will pay more."

Small businesses are one of the primary engines of American job creation. Imposing Massachusetts's expensive reforms on the entire nation is likely to put a drag on that engine for years to come.

Original Source: *http://article.nationalreview.com/438971/bay-state-health-care-blues/paul-howard*

[From the *Wall Street Journal,* February 1, 2011]

Judge Rejects Health Law

By JANET ADAMY

A federal judge ruled that Congress violated the Constitution by requiring Americans to buy insurance as part of the health overhaul passed last year, and said the entire law "must be declared void."

With his ruling, U.S. District Judge Roger Vinson set up a clash over whether the Obama administration still has the authority to carry out the law designed to expand insurance to 32 million Americans.

A Florida federal judge on Monday ruled that a key plank of the health overhaul passed last March violates the Constitution, in a decision that could threaten the Obama administration's ability to implement the law. Janet Adamy has details.

David Rivkin, an attorney for the plaintiffs, said the ruling meant the 26 states challenging the law must halt implementation of pieces that apply to states and certain small businesses represented by plaintiffs.

But the Obama administration said it has no to plans to halt implementation of the law. Already, it has mailed rebate checks to seniors with high prescription drug costs, helped set up insurance pools for people with pre-existing medical conditions and required insurers to allow children to stay on their parents' insurance policies until they reach age 26.

"We will continue to operate as we have previously," a senior administration official said.

In a pre-emptive move, the Justice Department, which represents the administration, is considering whether to seek a stay while its appeal against the decision is pending, spokeswoman Tracy Schmaler said.

The legal morass is the biggest blow yet to the law since President Barack Obama signed it in March. Most of the plaintiffs—governors and attorneys general in 26 states—are Republicans seeking to knock down Mr. Obama's signature legislative achievement.

The ruling by Judge Vinson, a Republican appointee in Pensacola, Fla., is the second of four to find that at least part of the law violates the Constitution's Commerce Clause by requiring citizens to carry insurance or pay a fee. But in asserting that the whole law is unconstitutional, it went much further than an earlier ruling in a Virginia case.

Thus far, the court decisions are breaking down along party lines, with two Democratic appointees to the federal bench having upheld the law and two Republican appointees ruling against it. The matter is expected to be settled by the U.S. Supreme Court.

The possibility that a court could ultimately unravel the law underscores just how difficult it is to enact universal health insurance—a goal that had eluded presidents dating back to Theodore Roosevelt. Mr. Obama's law, signed after a long-fought partisan battle, has been hailed by supporters as a historic achievement. But it is also one that cost Democrats seats in this fall's midterm elections, as the public was still divided in its support of the legislation.

The court battle against the law—once seen as a long-shot strategy by the Republicans—has emerged as the greatest threat to the overhaul. While the Republican-led House has voted to repeal the law, that effort is expected to die in the Democratic-controlled Senate, and in any case would face President Obama's veto pen.

Now even some Democrats who voted for the overhaul are contemplating whether Congress should strip out the so-called individual mandate, a once unthinkable scenario since the provision is seen as the backbone of the law. Since the law requires insurance companies to accept all comers, even people who are already sick, it requires healthy people to buy coverage as well.

Otherwise, economists say, insurance premiums would likely rise sharply because people would wait until they were sick to seek coverage.

The victories are emboldening Republicans in Congress who see attacking the law as a key strategy for retaking the White House in 2012. "This ruling confirms what Americans have been saying for months: The health spending bill is a massive overreach," said Senate Minority Leader Mitch McConnell (R., Ky.)

In his 78-page ruling, Judge Vinson wrote that the entire law must be voided because the individual insurance mandate is "not severable" from the rest of the law. Some laws contain what's known as a severability clause that says the rest of the law stands should a judge strike down a piece of it. But Democrats left it out.

The judge said he didn't believe an injunction to stop the health overhaul was appropriate, because it is generally understood that the executive branch will obey a federal court. The government, however, doesn't believe the ruling requires it to stop implementing the overhaul.

In court filings and testimony before the judge, the Obama administration argued that requiring Americans to carry insurance was within its constitutional powers, particularly those of the Commerce Clause that allows it to regulate economic activity. It argued that the health-care market is unique since all Americans receive medical care at some point. Requiring them to buy insurance is just a way of regulating how they pay for it, the administration said.

The ruling also said that the entire law "must be declared void," because the mandate to carry insurance is "not severable" from the rest of the law. Above, an imaging technician prepares a CAT scan machine at Timpanogos Regional Hospital in Orem, Utah.

Judge Vinson rejected that view. Under the Obama administration's logic, he wrote, "Congress could require that everyone above a certain income threshold buy a General Motors automobile—now partially government-owned—because those who do not buy GM cars (or those who buy foreign cars) are adversely impacting commerce and a taxpayer-subsidized business."

Judge Vinson ruled in favor of the Obama administration on a secondary part of the suit, saying that the law's expansion of the Medicaid federal-state insurance program for the poor doesn't violate the Constitution.

The states argued that the law's addition of 16 million Americans to the Medicaid rolls violates the Spending Clause of the Constitution by burdening them without giving them room to opt out of the program.

But Judge Vinson said states clearly have the option to withdraw from the program, even though states "have little recourse to remaining the very junior partner in this partnership."

Critics say the law's implementation has been undercut by waivers the administration granted to various parties to avoid aspects of the law. For example, the administration has temporarily exempted some companies that provide bare-bones "mini-med" insurance plans from meeting a requirement in the law that says insurers must spend a certain portion of premiums on medical care.

The Obama administration says such waivers are only a bridge until 2014, when the full law takes effect and employers have more options for providing affordable coverage.

In addition to the House vote for repeal, Republicans are drafting a series of bills targeting particularly unpopular pieces of the law, including its requirement that larger employers provide coverage or pay a fee. They're also laying plans to choke off funding to hire federal workers to implement the law.

Under the law, most Americans who do not carry insurance starting in 2014 will pay a penalty. It eventually tops out at $2,085 a year for families lacking insurance.

Health policy experts say one alternative to the provision would be to make insurance more expensive for those who wait to buy coverage, providing an incentive for the uninsured to get covered early. But lawmakers from both parties agree that it would be complicated, and risky, to pull out such a central piece of the law without driving up insurance premiums.

[From the *Wall Street Journal,* February 7, 2011]

An ObamaCare Appeal From the States

Twenty-one governors representing more than 115 million Americans have written to Kathleen Sebelius asking for more flexibility on health-care reform.

By MITCH DANIELS

Unless you're in favor of a fully nationalized health-care system, the president's health-care reform law is a massive mistake. It will amplify all the big drivers of overconsumption and excessive pricing: "Why not, it's free?" reimbursement; "The more I do, the more I get" provider payment; and all the defensive medicine the trial bar's ingenuity can generate.

All claims made for it were false. It will add trillions to the federal deficit. It will lead to a de facto government takeover of health care faster than most people realize, and as millions of Americans are added to the Medicaid rolls and millions more employees (including, watch for this, workers of bankrupt state governments) are dumped into the new exchanges.

Many of us governors are hoping for either a judicial or legislative rescue from this impending disaster, and recent court decisions suggest there's a chance of that. But we can't count on a miracle—that's only permitted in Washington policy making. We have no choice but to prepare for the very real possibility that the law takes effect in 2014.

For state governments, the bill presents huge new costs, as we are required to enroll 15 million to 20 million more people in our Medicaid systems. In Indiana, our independent actuaries have pegged the price to state taxpayers at $2.6 billion to $3 billion over the next 10 years. This is a huge burden for our state, and yet another incremental expenditure the law's authors declined to account for truthfully.

Perhaps worse, the law expects to conscript the states as its agents in its takeover of health care. It assumes that we will set up and operate its new insurance "exchanges" for it, using our current welfare apparatuses to do the numbingly complex work of figuring out who is eligible for its subsidies, how much each person or family is eligible for, redetermining this eligibility regularly, and more. Then, we are supposed to oversee all the insurance plans in the exchanges for compliance with Washington's dictates about terms and prices.

The default option if any state declines to participate is for the federal government to operate an exchange directly. Which got me thinking: If the new law is not repealed by 2013, what could be done to reshape it in the direction of freedom and genuine cost control?

I have written to Kathleen Sebelius, secretary of Health and Services (HHS), saying that if her department wants Indiana to run its program for it, we will do so under the following conditions:

• We are given the flexibility to decide which insurers are permitted to offer their products.

• All the law's expensive benefit mandates are waived, so that our citizens aren't forced to buy benefits they don't need and have a range of choice that includes more affordable plans.

• The law's provisions discriminating against consumer-driven plans, such as health savings accounts, are waived.

• We are given the freedom to move Medicaid beneficiaries into the exchange, or to utilize new approaches to the traditional program, instead of herding hundreds of thousands more people into today's broken Medicaid system.

• Our state is reimbursed the true, full cost of the administrative burden to be imposed upon us, based on the estimate of an auditor independent of HHS.

• A trustworthy projection is commissioned, by a research organization independent of the department, of how many people are likely to wind up in the exchange, given the large incentives for employers to save money by off-loading their workers.

Today's Rasmussen poll finds that Americans still favor repeal of the President's health-care reform. Senior editorial writer Joseph Rago has the latest. Also, Opinionjournal.com columnist John Fund on the unanswered questions about the Gipper.

Obviously, this is a very different system than the one the legislation intends. Health care would be much more affordable, minus all the mandates, and plus the consumer consciousness that comes with health savings accounts and their kin. Customer choice would be dramatically enhanced by the state's ability to allow more insurers to participate and offer consumer-driven plans. Through greater flexibility in the management of Medicaid, the state might be able to reduce substantially the hidden tax increase that forced expansion of the program will impose.

Most fundamentally, the system we are proposing requires Washington to abandon most of the command-and-control aspects of the law as written. It steers away from nanny-state paternalism by assuming, recognizing and reinforcing the dignity of all our citizens and their right to make health care's highly personal decisions for themselves.

So why would Ms. Sebelius and HHS agree to this de facto rewrite of their treasured accomplishment? A glance at the recent fiasco of high-risk pools provides the answer. When a majority of states, including Indiana, declined to participate in setting up these pools, which cover those with high-cost, existing conditions, the task fell to HHS. As widely reported, it went poorly, with costs far above predictions and only a tiny fraction of the expected population signing up.

If the feds can't manage this little project, what should we expect if they attempt it on a scale hundreds of times larger and more complex? If it were only Indiana asking, I have no doubt that HHS would ignore us. But Indiana is not alone. So far, 21 states—including Pennsylvania, Texas and Louisiana—have signed the same letter. We represent more than 115 million Americans. Washington's attempt to set up eligibility and exchange bureaucracies in all these places would invite a first-rate operational catastrophe.

If there's to be a train wreck, we governors would rather be spectators than conductors. But if the federal government is willing to reroute the train to a different, more productive track, we are here to help.

Mr. Daniels, a Republican, is the governor of Indiana.

[Whereupon, at 12:29 p.m., the committee was adjourned.]